

Senate Bill No. 50-A

An act relating to workers' compensation; amending s. 440.02, F.S.; providing, revising, and deleting definitions; amending s. 440.05, F.S.; revising authorization to claim exemptions and requirements relating to submitting notice of election of exemption; specifying effect of exemption; providing a definition; amending s. 440.06, F.S.; revising provisions relating to failure to secure compensation; amending s. 440.077, F.S.; providing that a corporate officer electing to be exempt may not receive benefits; amending s. 440.09, F.S.; revising provisions relating to compensation for subsequent injuries; providing definitions; revising provisions relating to drug testing; specifying effect of criminal acts; creating s. 440.093, F.S.; providing for compensability of mental and nervous injuries; amending s. 440.10, F.S.; revising provisions relating to contractors and subcontractors with regard to liability for compensation; requiring subcontractors to provide evidence of workers' compensation coverage or proof of exemption to a contractor; deleting provisions relating to independent contractors; amending s. 440.1025, F.S.; revising requirements relating to workplace safety programs; amending s. 440.103, F.S.; providing conditions for applying for building permits; amending s. 440.105, F.S.; increasing criminal penalties for certain violations; providing sanctions for violation of stop-work orders and presentation of certain false or misleading statements as evidence; amending s. 440.1051, F.S.; increasing criminal penalty for false reports; amending s. 440.107, F.S.; providing additional powers to the Department of Financial Services relating to compliance and enforcement; providing a definition; providing penalties; amending s. 440.11, F.S.; providing exclusiveness of liability; revising provisions relating to employer and safety consultant immunity from liability; amending s. 440.13, F.S.; providing for practice parameters and treatment protocols; revising provisions relating to provider reimbursement; requiring revision of specified reimbursement schedules; providing for release of information; providing additional criteria for independent medical examinations; providing a definition; providing standards for medical care under ch. 440, F.S.; providing penalties; amending s. 440.134, F.S.; revising provisions relating to managed care arrangements; revising definitions; providing for assignment of a medical care coordinator; amending s. 440.14, F.S.; revising provisions relating to calculation of average weekly wage for injured employees; conforming cross-references; amending s. 440.15, F.S.; providing additional limitations on compensation for permanent total disability; providing a definition; specifying impairment benefits and providing for partial reduction under certain circumstances; deleting provisions relating to supplemental benefits; amending s. 440.151, F.S.; specifying compensability of occupational disease; providing a definition; amending s. 440.16, F.S.; increasing the limits on the amount of certain benefits paid as compensation for death; amending s. 440.185, F.S.; specifying duty of employer upon receipt of notice of injury or death; in-

creasing penalties for noncompliance; amending s. 440.192, F.S.; revising procedure for resolving benefit disputes; requiring a petition for benefits to include all claims which are ripe, due, and owing; providing that the Chief Judge, rather than the Deputy Chief Judge, shall refer petitions for benefits; creating s. 440.1926, F.S.; providing for alternative dispute resolution and arbitration of claims; amending s. 440.20, F.S.; revising provisions relating to timely payment of compensation and medical bills and penalties for late payment; prohibiting the clerk of the circuit court from assessing certain fees or costs; amending s. 440.25, F.S.; revising procedures for mediation and hearings; amending s. 440.34, F.S.; revising provisions relating to the award of attorney's fees; amending s. 440.38, F.S.; providing requirement for employers with coverage provided by insurers from outside the state; amending s. 440.381, F.S.; providing criminal penalty for unlawful applications; requiring on-site audits of employers under certain circumstances; amending s. 440.42, F.S.; revising provision relating to notice of cancellation of coverage; amending s. 440.49, F.S., to conform cross-references; amending s. 440.491, F.S.; providing training and education requirements and benefits relating to reemployment of injured workers; providing for rules; amending s. 440.525, F.S.; providing for the Office of Insurance Regulation of the Financial Services Commission to conduct examinations and investigations of claims-handling entities; providing penalties; providing for rules; amending s. 627.162, F.S.; revising delinquency and collection fee for late payment of premium installments; creating s. 627.285, F.S.; providing for annual actuarial peer review of rating organization processes; requiring a report; amending s. 627.311, F.S.; revising membership of the board of governors of the workers' compensation joint underwriting plan; requiring participation in safety programs; providing for an additional subplan within the joint underwriting plan for workers' compensation insurance; providing for rates, surcharges, and assessments; limiting assessment powers; amending s. 921.0022, F.S.; revising the offense severity ranking chart to reflect changes in penalties under the act; requiring a report to the Legislature from the Department of Financial Services regarding provisions of law relating to enforcement; amending ss. 946.523 and 985.315, F.S., to conform cross-references; establishing a Joint Select Committee on Workers' Compensation Rating Reform and specifying duties thereof; providing for termination of the committee; requiring the board of governors of the workers' compensation joint underwriting plan to submit a report to the Legislature; amending s. 443.1715, F.S.; revising provisions relating to records and reports; providing for disclosure of specified information; amending s. 625.989, F.S.; providing that the Department of Financial Services shall prepare an annual report relating to workers' compensation fraud and compliance; amending s. 626.9891, F.S.; amending reporting requirements for insurers; providing penalties for noncompliance; providing for rules; repealing s. 440.1925, F.S., relating to procedure for resolving maximum medical improvement or permanent impairment disputes; amending ss. 112.19 and 112.191, F.S., to conform references to changes made by the act;

providing that amendments to ss. 440.02 and 440.15, F.S., do not affect certain disability, determination, and benefits; providing for construction of the act in pari materia with laws enacted during the 2003 Regular Session of the Legislature; providing effective dates.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Effective upon this act becoming a law, subsections (1), (15), (29), (38), (39), (40), (41), and (42) of section 440.02, Florida Statutes, are amended to read:

440.02 Definitions.—When used in this chapter, unless the context clearly requires otherwise, the following terms shall have the following meanings:

(1) “Accident” means only an unexpected or unusual event or result that happens suddenly. ~~A mental or nervous injury due to stress, fright, or excitement only, or~~ Disability or death due to the accidental acceleration or aggravation of a venereal disease or of a disease due to the habitual use of alcohol or controlled substances or narcotic drugs, or a disease that manifests itself in the fear of or dislike for an individual because of the individual’s race, color, religion, sex, national origin, age, or handicap is not an injury by accident arising out of the employment. Subject to s. 440.15(5), if a preexisting disease or anomaly is accelerated or aggravated by an accident arising out of and in the course of employment, only acceleration of death or acceleration or aggravation of the preexisting condition reasonably attributable to the accident is compensable, with respect to any compensation otherwise payable under this chapter death or permanent impairment. An injury or disease caused by exposure to a toxic substance, including, but not limited to, fungus or mold, is not an injury by accident arising out of the employment unless there is clear and convincing evidence establishing that exposure to the specific substance involved, at the levels to which the employee was exposed, can cause the injury or disease sustained by the employee.

(15)(a) “Employee” means any person engaged in any employment under any appointment or contract of hire or apprenticeship, express or implied, oral or written, whether lawfully or unlawfully employed, and includes, but is not limited to, aliens and minors.

(b) “Employee” includes any person who is an officer of a corporation and who performs services for remuneration for such corporation within this state, whether or not such services are continuous.

1. Any officer of a corporation may elect to be exempt from this chapter by filing written notice of the election with the department as provided in s. 440.05.

2. As to officers of a corporation who are actively engaged in the construction industry, no more than three officers may elect to be exempt from this chapter by filing written notice of the election with the department as provided in s. 440.05. ~~However, any exemption obtained by a corporate officer of a corporation actively engaged in the construction industry is not applica-~~

ble with respect to any commercial building project estimated to be valued at \$250,000 or greater.

3. An officer of a corporation who elects to be exempt from this chapter by filing a written notice of the election with the department as provided in s. 440.05 is not an employee.

Services are presumed to have been rendered to the corporation if the officer is compensated by other than dividends upon shares of stock of the corporation which the officer owns.

(c)1. “Employee” includes a sole proprietor or a partner who devotes full time to the proprietorship or partnership and, except as provided in this paragraph, elects to be included in the definition of employee by filing notice thereof as provided in s. 440.05. Partners or sole proprietors actively engaged in the construction industry are considered employees unless they elect to be excluded from the definition of employee by filing written notice of the election with the department as provided in s. 440.05. However, no more than three partners in a partnership that is actively engaged in the construction industry may elect to be excluded. A sole proprietor or partner who is actively engaged in the construction industry and who elects to be exempt from this chapter by filing a written notice of the election with the department as provided in s. 440.05 is not an employee. For purposes of this chapter, an independent contractor is an employee unless he or she meets all of the conditions set forth in subparagraph (d)1.

~~2. Notwithstanding the provisions of subparagraph 1., the term “employee” includes a sole proprietor or partner actively engaged in the construction industry with respect to any commercial building project estimated to be valued at \$250,000 or greater. Any exemption obtained is not applicable, with respect to work performed at such a commercial building project.~~

(d) “Employee” does not include:

1. An independent contractor, if:

a. The independent contractor maintains a separate business with his or her own work facility, truck, equipment, materials, or similar accommodations;

b. The independent contractor holds or has applied for a federal employer identification number, unless the independent contractor is a sole proprietor who is not required to obtain a federal employer identification number under state or federal requirements;

c. The independent contractor performs or agrees to perform specific services or work for specific amounts of money and controls the means of performing the services or work;

d. The independent contractor incurs the principal expenses related to the service or work that he or she performs or agrees to perform;

- e. The independent contractor is responsible for the satisfactory completion of work or services that he or she performs or agrees to perform and is or could be held liable for a failure to complete the work or services;
- f. The independent contractor receives compensation for work or services performed for a commission or on a per-job or competitive-bid basis and not on any other basis;
- g. The independent contractor may realize a profit or suffer a loss in connection with performing work or services;
- h. The independent contractor has continuing or recurring business liabilities or obligations; and
- i. The success or failure of the independent contractor's business depends on the relationship of business receipts to expenditures.

However, the determination as to whether an individual included in the Standard Industrial Classification Manual of 1987, Industry Numbers 0711, 0721, 0722, 0751, 0761, 0762, 0781, 0782, 0783, 0811, 0831, 0851, 2411, 2421, 2435, 2436, 2448, or 2449, or a newspaper delivery person, is an independent contractor is governed not by the criteria in this paragraph but by common-law principles, giving due consideration to the business activity of the individual. ~~Notwithstanding the provisions of this paragraph or any other provision of this chapter, with respect to any commercial building project estimated to be valued at \$250,000 or greater, a person who is actively engaged in the construction industry is not an independent contractor and is either an employer or an employee who may not be exempt from the coverage requirements of this chapter.~~

2. A real estate salesperson or agent, if that person agrees, in writing, to perform for remuneration solely by way of commission.
3. Bands, orchestras, and musical and theatrical performers, including disk jockeys, performing in licensed premises as defined in chapter 562, if a written contract evidencing an independent contractor relationship is entered into before the commencement of such entertainment.
4. An owner-operator of a motor vehicle who transports property under a written contract with a motor carrier which evidences a relationship by which the owner-operator assumes the responsibility of an employer for the performance of the contract, if the owner-operator is required to furnish the necessary motor vehicle equipment and all costs incidental to the performance of the contract, including, but not limited to, fuel, taxes, licenses, repairs, and hired help; and the owner-operator is paid a commission for transportation service and is not paid by the hour or on some other time-measured basis.
5. A person whose employment is both casual and not in the course of the trade, business, profession, or occupation of the employer.
6. A volunteer, except a volunteer worker for the state or a county, municipality, or other governmental entity. A person who does not receive

monetary remuneration for services is presumed to be a volunteer unless there is substantial evidence that a valuable consideration was intended by both employer and employee. For purposes of this chapter, the term “volunteer” includes, but is not limited to:

a. Persons who serve in private nonprofit agencies and who receive no compensation other than expenses in an amount less than or equivalent to the standard mileage and per-diem expenses provided to salaried employees in the same agency or, if such agency does not have salaried employees who receive mileage and per diem, then such volunteers who receive no compensation other than expenses in an amount less than or equivalent to the customary mileage and per diem paid to salaried workers in the community as determined by the department; and

b. Volunteers participating in federal programs established under Pub. L. No. 93-113.

7. Any officer of a corporation who elects to be exempt from this chapter.

8. A sole proprietor or officer of a corporation who actively engages in the construction industry, and a partner in a partnership that is actively engaged in the construction industry, who elects to be exempt from the provisions of this chapter. Such sole proprietor, officer, or partner is not an employee for any reason until the notice of revocation of election filed pursuant to s. 440.05 is effective.

9. An exercise rider who does not work for a single horse farm or breeder, and who is compensated for riding on a case-by-case basis, provided a written contract is entered into prior to the commencement of such activity which evidences that an employee/employer relationship does not exist.

10. A taxicab, limousine, or other passenger vehicle-for-hire driver who operates said vehicles pursuant to a written agreement with a company which provides any dispatch, marketing, insurance, communications, or other services under which the driver and any fees or charges paid by the driver to the company for such services are not conditioned upon, or expressed as a proportion of, fare revenues.

11. A person who performs services as a sports official for an entity sponsoring an interscholastic sports event or for a public entity or private, nonprofit organization that sponsors an amateur sports event. For purposes of this subparagraph, such a person is an independent contractor. For purposes of this subparagraph, the term “sports official” means any person who is a neutral participant in a sports event, including, but not limited to, umpires, referees, judges, linespersons, scorekeepers, or timekeepers. This subparagraph does not apply to any person employed by a district school board who serves as a sports official as required by the employing school board or who serves as a sports official as part of his or her responsibilities during normal school hours.

(29) “Weekly compensation rate” means and refers to the amount of compensation payable for a period of 7 consecutive calendar days, including any Saturdays, Sundays, holidays, and other nonworking days which fall

within such period of 7 consecutive calendar days. When Saturdays, Sundays, holidays, or other nonworking days immediately follow the first 7 calendar days of disability or occur at the end of a period of disability as the last day or days of such period, such nonworking days constitute a part of the period of disability with respect to which compensation is payable.

~~(38) “Catastrophic injury” means a permanent impairment constituted by:~~

~~(a) Spinal cord injury involving severe paralysis of an arm, a leg, or the trunk;~~

~~(b) Amputation of an arm, a hand, a foot, or a leg involving the effective loss of use of that appendage;~~

~~(c) Severe brain or closed-head injury as evidenced by:~~

~~1. Severe sensory or motor disturbances;~~

~~2. Severe communication disturbances;~~

~~3. Severe complex integrated disturbances of cerebral function;~~

~~4. Severe episodic neurological disorders; or~~

~~5. Other severe brain and closed-head injury conditions at least as severe in nature as any condition provided in subparagraphs 1.-4.;~~

~~(d) Second-degree or third-degree burns of 25 percent or more of the total body surface or third-degree burns of 5 percent or more to the face and hands;~~

~~(e) Total or industrial blindness; or~~

~~(f) Any other injury that would otherwise qualify under this chapter of a nature and severity that would qualify an employee to receive disability income benefits under Title II or supplemental security income benefits under Title XVI of the federal Social Security Act as the Social Security Act existed on July 1, 1992, without regard to any time limitations provided under that act.~~

~~(38)(39) “Insurer” means a group self-insurers’ fund authorized by s. 624.4621, an individual self-insurer authorized by s. 440.38, a commercial self-insurance fund authorized by s. 624.462, an assessable mutual insurer authorized by s. 628.6011, and an insurer licensed to write workers’ compensation and employer’s liability insurance in this state. The term “carrier,” as used in this chapter, means an insurer as defined in this subsection.~~

~~(39)(40) “Statement,” for the purposes of ss. 440.105 and 440.106, shall include the exact fraud statement language in s. 440.105(7). This requirement includes, but is not limited to, any notice, representation, statement, proof of injury, bill for services, diagnosis, prescription, hospital or doctor record, X ray, test result, or other evidence of loss, injury, or expense.~~

~~(40)(41) “Specificity” means information on the petition for benefits sufficient to put the employer or carrier on notice of the exact statutory classification and outstanding time period of benefits being requested and includes a detailed explanation of any benefits received that should be increased, decreased, changed, or otherwise modified. If the petition is for medical benefits, the information shall include specific details as to why such benefits are being requested, why such benefits are medically necessary, and why current treatment, if any, is not sufficient. Any petition requesting alternate or other medical care, including, but not limited to, petitions requesting psychiatric or psychological treatment, must specifically identify the physician, as defined in s. 440.13(1), that is recommending such treatment. A copy of a report from such physician making the recommendation for alternate or other medical care shall also be attached to the petition. A judge of compensation claims shall not order such treatment if a physician is not recommending such treatment. “Commercial building” means any building or structure intended for commercial or industrial use, or any building or structure intended for multifamily use of more than four dwelling units, as well as any accessory use structures constructed in conjunction with the principal structure. The term, “commercial building,” does not include the conversion of any existing residential building to a commercial building.~~

~~(42) “Residential building” means any building or structure intended for residential use containing four or fewer dwelling units and any structures intended as an accessory use to the residential structure.~~

Section 2. Effective January 1, 2004, subsections (8), (15), and (16) of section 440.02, Florida Statutes, as amended by this act, are amended to read:

440.02 Definitions.—When used in this chapter, unless the context clearly requires otherwise, the following terms shall have the following meanings:

(8) ~~“Construction industry” means for-profit activities involving the carrying out of any building, clearing, filling, excavation, or substantial improvement in the size or use of any structure or the appearance of any land. When appropriate to the context, “construction” refers to the act of construction or the result of construction. However, “construction” does shall not mean a homeowner’s landowner’s act of construction or the result of a construction upon his or her own premises, provided such premises are not intended to be sold, or resold, or leased by the owner within 1 year after the commencement of construction. The division may, by rule, establish standard industrial classification codes and definitions thereof which meet the criteria of the term “construction industry” as set forth in this section.~~

(15)(a) ~~“Employee” means any person who receives remuneration from an employer for the performance of any work or service while engaged in any employment under any appointment or contract for of hire or apprenticeship, express or implied, oral or written, whether lawfully or unlawfully employed, and includes, but is not limited to, aliens and minors.~~

(b) ~~“Employee” includes any person who is an officer of a corporation and who performs services for remuneration for such corporation within this state, whether or not such services are continuous.~~

1. Any officer of a corporation may elect to be exempt from this chapter by filing written notice of the election with the department as provided in s. 440.05.

2. As to officers of a corporation who are actively engaged in the construction industry, no more than three officers of a corporation or of any group of affiliated corporations may elect to be exempt from this chapter by filing written notice of the election with the department as provided in s. 440.05. Officers must be shareholders, each owning at least 10 percent of the stock of such corporation and listed as an officer of such corporation with the Division of Corporations of the Department of State, in order to elect exemptions under this chapter. For purposes of this subparagraph, the term “affiliated” means and includes one or more corporations or entities, any one of which is a corporation engaged in the construction industry, under the same or substantially the same control of a group of business entities which are connected or associated so that one entity controls or has the power to control each of the other business entities. The term “affiliated” includes, but is not limited to, the officers, directors, executives, shareholders active in management, employees, and agents of the affiliated corporation. The ownership by one business entity of a controlling interest in another business entity or a pooling of equipment or income among business entities shall be prima facie evidence that one business is affiliated with the other.

3. An officer of a corporation who elects to be exempt from this chapter by filing a written notice of the election with the department as provided in s. 440.05 is not an employee.

Services are presumed to have been rendered to the corporation if the officer is compensated by other than dividends upon shares of stock of the corporation which the officer owns.

(c) “Employee” includes:

~~1. A sole proprietor or a partner who is not engaged in the construction industry, devotes full time to the proprietorship or partnership, and, except as provided in this paragraph, elects to be included in the definition of employee by filing notice thereof as provided in s. 440.05. Partners or sole proprietors actively engaged in the construction industry are considered employees unless they elect to be excluded from the definition of employee by filing written notice of the election with the department as provided in s. 440.05. However, no more than three partners in a partnership that is actively engaged in the construction industry may elect to be excluded. A sole proprietor or partner who is actively engaged in the construction industry and who elects to be exempt from this chapter by filing a written notice of the election with the department as provided in s. 440.05 is not an employee. For purposes of this chapter, an independent contractor is an employee unless he or she meets all of the conditions set forth in subparagraph (d)1.~~

2. All persons who are being paid by a construction contractor as a subcontractor, unless the subcontractor has validly elected an exemption as permitted by this chapter, or has otherwise secured the payment of compen-

sation coverage as a subcontractor, consistent with s. 440.10, for work performed by or as a subcontractor.

3. An independent contractor working or performing services in the construction industry.

4. A sole proprietor who engages in the construction industry and a partner or partnership that is engaged in the construction industry.

(d) "Employee" does not include:

1. An independent contractor who is not engaged in the construction industry, if:

a. In order to meet the definition of independent contractor, at least four of the following criteria must be met:

(I) The independent contractor maintains a separate business with his or her own work facility, truck, equipment, materials, or similar accommodations;

(II) The independent contractor holds or has applied for a federal employer identification number, unless the independent contractor is a sole proprietor who is not required to obtain a federal employer identification number under state or federal regulations;

(III) The independent contractor receives compensation for services rendered or work performed and such compensation is paid to a business rather than to an individual;

(IV) The independent contractor holds one or more bank accounts in the name of the business entity for purposes of paying business expenses or other expenses related to services rendered or work performed for compensation;

(V) The independent contractor performs work or is able to perform work for any entity in addition to or besides the employer at his or her own election without the necessity of completing an employment application or process; or

(VI) The independent contractor receives compensation for work or services rendered on a competitive-bid basis or completion of a task or a set of tasks as defined by a contractual agreement, unless such contractual agreement expressly states that an employment relationship exists. The independent contractor maintains a separate business with his or her own work facility, truck, equipment, materials, or similar accommodations;

b. If four of the criteria listed in sub-subparagraph a. do not exist, an individual may still be presumed to be an independent contractor and not an employee based on full consideration of the nature of the individual situation with regard to satisfying any of the following conditions:

(I) The independent contractor performs or agrees to perform specific services or work for a specific amount of money and controls the means of performing the services or work.

(II) The independent contractor incurs the principal expenses related to the service or work that he or she performs or agrees to perform.

(III) The independent contractor is responsible for the satisfactory completion of the work or services that he or she performs or agrees to perform.

(IV) The independent contractor receives compensation for work or services performed for a commission or on a per-job basis and not on any other basis.

(V) The independent contractor may realize a profit or suffer a loss in connection with performing work or services.

(VI) The independent contractor has continuing or recurring business liabilities or obligations.

(VII) The success or failure of the independent contractor's business depends on the relationship of business receipts to expenditures. The independent contractor holds or has applied for a federal employer identification number, unless the independent contractor is a sole proprietor who is not required to obtain a federal employer identification number under state or federal requirements;

c. Notwithstanding anything to the contrary in this subparagraph, an individual claiming to be an independent contractor has the burden of proving that he or she is an independent contractor for purposes of this chapter. The independent contractor performs or agrees to perform specific services or work for specific amounts of money and controls the means of performing the services or work;

d. The independent contractor incurs the principal expenses related to the service or work that he or she performs or agrees to perform;

e. The independent contractor is responsible for the satisfactory completion of work or services that he or she performs or agrees to perform and is or could be held liable for a failure to complete the work or services;

f. The independent contractor receives compensation for work or services performed for a commission or on a per-job or competitive-bid basis and not on any other basis;

g. The independent contractor may realize a profit or suffer a loss in connection with performing work or services;

h. The independent contractor has continuing or recurring business liabilities or obligations; and

i. The success or failure of the independent contractor's business depends on the relationship of business receipts to expenditures.

However, the determination as to whether an individual included in the Standard Industrial Classification Manual of 1987, Industry Numbers 0711, 0721, 0722, 0751, 0761, 0762, 0781, 0782, 0783, 0811, 0831, 0851, 2411,

~~2421, 2435, 2436, 2448, or 2449, or a newspaper delivery person, is an independent contractor is governed not by the criteria in this paragraph but by common-law principles, giving due consideration to the business activity of the individual.~~

2. A real estate salesperson or agent, if that person agrees, in writing, to perform for remuneration solely by way of commission.

3. Bands, orchestras, and musical and theatrical performers, including disk jockeys, performing in licensed premises as defined in chapter 562, if a written contract evidencing an independent contractor relationship is entered into before the commencement of such entertainment.

4. An owner-operator of a motor vehicle who transports property under a written contract with a motor carrier which evidences a relationship by which the owner-operator assumes the responsibility of an employer for the performance of the contract, if the owner-operator is required to furnish the necessary motor vehicle equipment and all costs incidental to the performance of the contract, including, but not limited to, fuel, taxes, licenses, repairs, and hired help; and the owner-operator is paid a commission for transportation service and is not paid by the hour or on some other time-measured basis.

5. A person whose employment is both casual and not in the course of the trade, business, profession, or occupation of the employer.

6. A volunteer, except a volunteer worker for the state or a county, municipality, or other governmental entity. A person who does not receive monetary remuneration for services is presumed to be a volunteer unless there is substantial evidence that a valuable consideration was intended by both employer and employee. For purposes of this chapter, the term "volunteer" includes, but is not limited to:

a. Persons who serve in private nonprofit agencies and who receive no compensation other than expenses in an amount less than or equivalent to the standard mileage and per diem expenses provided to salaried employees in the same agency or, if such agency does not have salaried employees who receive mileage and per diem, then such volunteers who receive no compensation other than expenses in an amount less than or equivalent to the customary mileage and per diem paid to salaried workers in the community as determined by the department; and

b. Volunteers participating in federal programs established under Pub. L. No. 93-113.

7. Unless otherwise prohibited by this chapter, any officer of a corporation who elects to be exempt from this chapter. Such officer is not an employee for any reason under this chapter until the notice of revocation of election filed pursuant to s. 440.05 is effective.

8. ~~An a sole proprietor or officer of a corporation who actively engages in the construction industry, and a partner in a partnership that is actively engaged in the construction industry, who elects to be exempt from the~~

provisions of this chapter, as otherwise permitted by this chapter. Such sole proprietor, officer, or partner is not an employee for any reason until the notice of revocation of election filed pursuant to s. 440.05 is effective.

9. An exercise rider who does not work for a single horse farm or breeder, and who is compensated for riding on a case-by-case basis, provided a written contract is entered into prior to the commencement of such activity which evidences that an employee/employer relationship does not exist.

10. A taxicab, limousine, or other passenger vehicle-for-hire driver who operates said vehicles pursuant to a written agreement with a company which provides any dispatch, marketing, insurance, communications, or other services under which the driver and any fees or charges paid by the driver to the company for such services are not conditioned upon, or expressed as a proportion of, fare revenues.

11. A person who performs services as a sports official for an entity sponsoring an interscholastic sports event or for a public entity or private, nonprofit organization that sponsors an amateur sports event. For purposes of this subparagraph, such a person is an independent contractor. For purposes of this subparagraph, the term "sports official" means any person who is a neutral participant in a sports event, including, but not limited to, umpires, referees, judges, linespersons, scorekeepers, or timekeepers. This subparagraph does not apply to any person employed by a district school board who serves as a sports official as required by the employing school board or who serves as a sports official as part of his or her responsibilities during normal school hours.

12. Medicaid-enrolled clients under chapter 393 who are excluded from the definition of employment under s. 443.036(21)(d)5. and served by Adult Day Training Services under the Home and Community-Based Medicaid Waiver program in a sheltered workshop setting licensed by the United States Department of Labor for the purpose of training and earning less than the federal hourly minimum wage.

(16)(a) "Employer" means the state and all political subdivisions thereof, all public and quasi-public corporations therein, every person carrying on any employment, and the legal representative of a deceased person or the receiver or trustees of any person. "Employer" also includes employment agencies, employee leasing companies, and similar agents who provide employees to other persons. If the employer is a corporation, parties in actual control of the corporation, including, but not limited to, the president, officers who exercise broad corporate powers, directors, and all shareholders who directly or indirectly own a controlling interest in the corporation, are considered the employer for the purposes of ss. 440.105, ~~and~~ 440.106, and 440.107.

(b) A homeowner shall not be considered the employer of persons hired by the homeowner to carry out construction on the homeowner's own premises if those premises are not intended for immediate lease, sale, or resale.

(c) Facilities serving individuals under subparagraph (15)(d)12. shall be considered agents of the Agency for Health Care Administration as it relates

to providing Adult Day Training Services under the Home and Community-Based Medicaid Waiver program and not employers or third parties for the purpose of limiting or denying Medicaid benefits.

Section 3. Effective January 1, 2004, subsections (3), (4), (6), (10), (11), and (12) of section 440.05, Florida Statutes, are amended, present subsection (13) is renumbered as subsection (11) and amended, and new subsections (12), (13), (14), and (15) are added to said section, to read:

440.05 Election of exemption; revocation of election; notice; certification.—

(3) Each ~~sole proprietor, partner, or officer~~ of a corporation who is ~~actively~~ engaged in the construction industry and who elects an exemption from this chapter or who, after electing such exemption, revokes that exemption, must mail a written notice to such effect to the department on a form prescribed by the department. The notice of election to be exempt from the provisions of this chapter must be notarized and under oath. The notice of election to be exempt which is submitted to the department by the ~~sole proprietor, partner, or officer~~ of a corporation who is allowed to claim an exemption as provided by this chapter must list the name, federal tax identification number, social security number, all certified or registered licenses issued pursuant to chapter 489 held by the person seeking the exemption, a copy of relevant documentation as to employment status filed with the Internal Revenue Service as specified by the department, a copy of the relevant occupational license in the primary jurisdiction of the business, and, ~~for corporate officers and partners,~~ the registration number of the corporation ~~or partnership~~ filed with the Division of Corporations of the Department of State along with a copy of the stock certificate evidencing the required ownership under this chapter. The notice of election to be exempt must identify each ~~sole proprietorship, partnership, or corporation~~ that employs the person electing the exemption and must list the social security number or federal tax identification number of each such employer and the additional documentation required by this section. In addition, the notice of election to be exempt must provide that the ~~sole proprietor, partner, or officer~~ electing an exemption is not entitled to benefits under this chapter, must provide that the election does not exceed exemption limits for officers ~~and partnerships~~ provided in s. 440.02, and must certify that any employees of the ~~corporation whose sole proprietor, partner, or officer elects~~ electing an exemption are covered by workers' compensation insurance. Upon receipt of the notice of the election to be exempt, receipt of all application fees, and a determination by the department that the notice meets the requirements of this subsection, the department shall issue a certification of the election to the ~~sole proprietor, partner, or officer,~~ unless the department determines that the information contained in the notice is invalid. The department shall revoke a certificate of election to be exempt from coverage upon a determination by the department that the person does not meet the requirements for exemption or that the information contained in the notice of election to be exempt is invalid. The certificate of election must list the name ~~names~~ of the ~~sole proprietorship, partnership, or corporation~~ listed in the request for exemption. A new certificate of election must be obtained each time the person is employed by a new ~~sole proprietorship, partnership, or~~ different

corporation that is not listed on the certificate of election. A copy of the certificate of election must be sent to each workers' compensation carrier identified in the request for exemption. Upon filing a notice of revocation of election, an ~~a sole proprietor, partner, or officer~~ who is a subcontractor or an officer of a corporate subcontractor must notify her or his contractor. Upon revocation of a certificate of election of exemption by the department, the department shall notify the workers' compensation carriers identified in the request for exemption.

(4) The notice of election to be exempt from the provisions of this chapter must contain a notice that clearly states in substance the following: "Any person who, knowingly and with intent to injure, defraud, or deceive the department or any employer or employee, insurance company, or any other person ~~purposes program~~, files a notice of election to be exempt containing any false or misleading information is guilty of a felony of the third degree." Each person filing a notice of election to be exempt shall personally sign the notice and attest that he or she has reviewed, understands, and acknowledges the foregoing notice.

(6) A construction industry certificate of election to be exempt which is issued in accordance with this section shall be valid for 2 years after the effective date stated thereon. Both the effective date and the expiration date must be listed on the face of the certificate by the department. The construction industry certificate must expire at midnight, 2 years from its issue date, as noted on the face of the exemption certificate. Any person who has received from the division a construction industry certificate of election to be exempt which is in effect on December 31, 1998, shall file a new notice of election to be exempt by the last day in his or her birth month following December 1, 1998. A construction industry certificate of election to be exempt may be revoked before its expiration by the ~~sole proprietor, partner, or officer~~ for whom it was issued or by the department for the reasons stated in this section. At least 60 days prior to the expiration date of a construction industry certificate of exemption issued after December 1, 1998, the department shall send notice of the expiration date and an application for renewal to the certificateholder at the address on the certificate.

(10) Each ~~sole proprietor, partner, or officer~~ of a corporation who is actively engaged in the construction industry and who elects an exemption from this chapter shall maintain business records as specified by the division by rule, which rules must include the provision that any corporation with exempt officers and ~~any partnership~~ actively engaged in the construction industry ~~with exempt partners~~ must maintain written statements of those exempted persons affirmatively acknowledging each such individual's exempt status.

(11) ~~Any sole proprietor or partner actively engaged in the construction industry claiming an exemption under this section shall maintain a copy of his or her federal income tax records for each of the immediately previous 3 years in which he or she claims an exemption. Such federal income tax records must include a complete copy of the following for each year in which an exemption is claimed:~~

(a) ~~For sole proprietors, a copy of Federal Income Tax Form 1040 and its accompanying Schedule C;~~

(b) ~~For partners, a copy of the partner's Federal Income Tax Schedule K-1 (Form 1065) and Federal Income Tax Form 1040 and its accompanying Schedule E.~~

~~A sole proprietor or partner shall produce, upon request by the division, a copy of those documents together with a statement by the sole proprietor or partner that the tax records provided are true and accurate copies of what the sole proprietor or partner has filed with the federal Internal Revenue Service. The statement must be signed under oath by the sole proprietor or partner and must be notarized. The division shall issue a stop-work order under s. 440.107(5) to any sole proprietor or partner who fails or refuses to produce a copy of the tax records and affidavit required under this paragraph to the division within 3 business days after the request is made.~~

~~(12) For those sole proprietors or partners that have not been in business long enough to provide the information required of an established business, the division shall require such sole proprietor or partner to provide copies of the most recently filed Federal Income Tax Form 1040. The division shall establish by rule such other criteria to show that the sole proprietor or partner intends to engage in a legitimate enterprise within the construction industry and is not otherwise attempting to evade the requirements of this section. The division shall establish by rule the form and format of financial information required to be submitted by such employers.~~

~~(11)(13) Any corporate officer permitted by this chapter to claim elaiming an exemption under this section must be listed on the records of this state's Secretary of State, Division of Corporations, as a corporate officer. If the person who claims an exemption as a corporate officer is not so listed on the records of the Secretary of State, the individual must provide to the division, upon request by the division, a notarized affidavit stating that the individual is a bona fide officer of the corporation and stating the date his or her appointment or election as a corporate officer became or will become effective. The statement must be signed under oath by both the officer and the president or chief operating officer of the corporation and must be notarized. The division shall issue a stop-work order under s. 440.107(1) to any corporation who employs a person who claims to be exempt as a corporate officer but who fails or refuses to produce the documents required under this subsection to the division within 3 business days after the request is made.~~

~~(12) Certificates of election to be exempt issued under subsection (3) shall apply only to the corporate officer named on the notice of election to be exempt and apply only within the scope of the business or trade listed on the notice of election to be exempt.~~

~~(13) Notices of election to be exempt and certificates of election to be exempt shall be subject to revocation if, at any time after the filing of the notice or the issuance of the certificate, the person named on the notice or certificate no longer meets the requirements of this section for issuance of a certificate. The department shall revoke a certificate at any time for failure~~

of the person named on the certificate to meet the requirements of this section.

(14) An officer of a corporation who elects exemption from this chapter by filing a certificate of election under this section may not recover benefits or compensation under this chapter. For purposes of determining the appropriate premium for workers' compensation coverage, carriers may not consider any officer of a corporation who validly meets the requirements of this section to be an employee.

(15) Any corporate officer who is an affiliated person of a person who is delinquent in paying a stop-work order and penalty assessment order issued pursuant to s. 440.107, or owed pursuant to a court order, is ineligible for an election of exemption. The stop-work order and penalty assessment shall be in effect against any such affiliated person. As used in this subsection, the term "affiliated person" means:

(a) The spouse of such other person;

(b) Any person who directly or indirectly owns or controls, or holds with the power to vote, 10 percent or more of the outstanding voting securities of such other person;

(c) Any person who directly or indirectly owns 10 percent or more of the outstanding voting securities that are directly or indirectly owned, controlled, or held with the power to vote by such other person;

(d) Any person or group of persons who directly or indirectly control, are controlled by, or are under common control with such other person;

(e) Any person who directly or indirectly acquires all or substantially all of the other assets of such other person;

(f) Any officer, director, trustee, partner, owner, manager, joint venturer, or employee of such other person or a person performing duties similar to persons in such positions; or

(g) Any person who has an officer, director, trustee, partner, or joint venturer in common with such person.

Section 4. Section 440.06, Florida Statutes, is amended to read:

440.06 Failure to secure compensation; effect.—Every employer who fails to secure the payment of compensation, as provided in s. 440.10, by failing to meet the requirements of ~~under this chapter as provided in s. 440.38~~ may not, in any suit brought against him or her by an employee subject to this chapter to recover damages for injury or death, defend such a suit on the grounds that the injury was caused by the negligence of a fellow servant, that the employee assumed the risk of his or her employment, or that the injury was due to the comparative negligence of the employee.

Section 5. Effective January 1, 2004, section 440.077, Florida Statutes, is amended to read:

440.077 When a ~~corporate sole proprietor, partner, or officer~~ rejects chapter, effect.—~~An A sole proprietor, partner, or officer~~ of a corporation who is permitted to elect an exemption under this chapter actively engaged in the construction industry and who elects to be exempt from the provisions of this chapter may not recover benefits under this chapter.

Section 6. Subsections (1) and (4) of section 440.09, Florida Statutes, are amended and paragraph (e) is added to subsection (7) of said section, to read:

440.09 Coverage.—

(1) The employer ~~must shall~~ pay compensation or furnish benefits required by this chapter if the employee suffers an accidental compensable injury or death arising out of work performed in the course and the scope of employment. The injury, its occupational cause, and any resulting manifestations or disability must shall be established to a reasonable degree of medical certainty, based on and by objective relevant medical findings, and the accidental compensable injury must be the major contributing cause of any resulting injuries. For purposes of this section, “major contributing cause” means the cause which is more than 50 percent responsible for the injury as compared to all other causes combined for which treatment or benefits are sought. In cases involving occupational disease or repetitive exposure, both causation and sufficient exposure to support causation must be proven by clear and convincing evidence. Pain or other subjective complaints alone, in the absence of objective relevant medical findings, are not compensable. For purposes of this section, “objective relevant medical findings” are those objective findings that correlate to the subjective complaints of the injured employee and are confirmed by physical examination findings or diagnostic testing. Establishment of the causal relationship between a compensable accident and injuries for conditions that are not readily observable must be by medical evidence only, as demonstrated by physical examination findings or diagnostic testing. Major contributing cause must be demonstrated by medical evidence only. Mental or nervous injuries occurring as a manifestation of an injury compensable under this section shall be demonstrated by clear and convincing evidence.

(a) This chapter does not require any compensation or benefits for any subsequent injury the employee suffers as a result of an original injury arising out of and in the course of employment unless the original injury is the major contributing cause of the subsequent injury. Major contributing cause must be demonstrated by medical evidence only.

(b) If an injury arising out of and in the course of employment combines with a preexisting disease or condition to cause or prolong disability or need for treatment, the employer must pay compensation or benefits required by this chapter only to the extent that the injury arising out of and in the course of employment is and remains more than 50 percent responsible for the injury as compared to all other causes combined and thereafter remains the major contributing cause of the disability or need for treatment. Major contributing cause must be demonstrated by medical evidence only.

(c) Death resulting from an operation by a surgeon furnished by the employer for the cure of hernia as required in s. 440.15(6) [F.S. 1981] shall

for the purpose of this chapter be considered to be a death resulting from the accident causing the hernia.

(d) If an accident happens while the employee is employed elsewhere than in this state, which would entitle the employee or his or her dependents to compensation if it had happened in this state, the employee or his or her dependents are entitled to compensation if the contract of employment was made in this state, or the employment was principally localized in this state. However, if an employee receives compensation or damages under the laws of any other state, the total compensation for the injury may not be greater than is provided in this chapter.

(4)(a) An employee shall not be entitled to compensation or benefits under this chapter if any judge of compensation claims, administrative law judge, court, or jury convened in this state determines that the employee has knowingly or intentionally engaged in any of the acts described in s. 440.105 or any criminal act for the purpose of securing workers' compensation benefits. For purposes of this section, the term "intentional" shall include, but is not limited to, pleas of guilty or nolo contendere in criminal matters. This section shall apply to accidents, regardless of the date of the accident. For injuries occurring prior to January 1, 1994, this section shall pertain to the acts of the employee described in s. 440.105 or criminal activities occurring subsequent to January 1, 1994.

(b) A judge of compensation claims, administrative law judge, or court of this state shall take judicial notice of a finding of insurance fraud by a court of competent jurisdiction and terminate or otherwise disallow benefits.

(c) Upon the denial of benefits in accordance with this section, a judge of compensation claims shall have the jurisdiction to order any benefits payable to the employee to be paid into the court registry or an escrow account during the pendency of an appeal or until such time as the time in which to file an appeal has expired.

(7)

(e) As a part of rebutting any presumptions under paragraph (b), the injured worker must prove the actual quantitative amounts of the drug or its metabolites as measured on the initial and confirmation post-accident drug tests of the injured worker's urine sample and provide additional evidence regarding the absence of drug influence other than the worker's denial of being under the influence of a drug. No drug test conducted on a urine sample shall be rejected as to its results or the presumption imposed under paragraph (b) on the basis of the urine being bodily fluid tested.

Section 7. Section 440.093, Florida Statutes, is created to read:

440.093 Mental and nervous injuries.—

(1) A mental or nervous injury due to stress, fright, or excitement only is not an injury by accident arising out of the employment. Nothing in this section shall be construed to allow for the payment of benefits under this chapter for mental or nervous injuries without an accompanying physical

injury requiring medical treatment. A physical injury resulting from mental or nervous injuries unaccompanied by physical trauma requiring medical treatment shall not be compensable under this chapter.

(2) Mental or nervous injuries occurring as a manifestation of an injury compensable under this chapter shall be demonstrated by clear and convincing medical evidence by a licensed psychiatrist meeting criteria established in the most recent edition of the diagnostic and statistical manual of mental disorders published by the American Psychiatric Association. The compensable physical injury must be and remain the major contributing cause of the mental or nervous condition and the compensable physical injury as determined by reasonable medical certainty must be at least 50 percent responsible for the mental or nervous condition as compared to all other contributing causes combined. Compensation is not payable for the mental, psychological, or emotional injury arising out of depression from being out of work or losing employment opportunities, resulting from a preexisting mental, psychological, or emotional condition or due to pain or other subjective complaints that cannot be substantiated by objective, relevant medical findings.

(3) Subject to the payment of permanent benefits under s. 440.15, in no event shall temporary benefits for a compensable mental or nervous injury be paid for more than 6 months after the date of maximum medical improvement for the injured employee's physical injury or injuries, which shall be included in the period of 104 weeks as provided in s. 440.15(2) and (4). Mental or nervous injuries are compensable only in accordance with the terms of this section.

Section 8. Effective January 1, 2004, subsection (1) of section 440.10, Florida Statutes, is amended to read:

440.10 Liability for compensation.—

(1)(a) Every employer coming within the provisions of this chapter, ~~including any brought within the chapter by waiver of exclusion or of exemption,~~ shall be liable for, and shall secure, the payment to his or her employees, or any physician, surgeon, or pharmacist providing services under the provisions of s. 440.13, of the compensation payable under ss. 440.13, 440.15, and 440.16. Any contractor or subcontractor who engages in any public or private construction in the state shall secure and maintain compensation for his or her employees under this chapter as provided in s. 440.38.

(b) In case a contractor sublets any part or parts of his or her contract work to a subcontractor or subcontractors, all of the employees of such contractor and subcontractor or subcontractors engaged on such contract work shall be deemed to be employed in one and the same business or establishment,; and the contractor shall be liable for, and shall secure, the payment of compensation to all such employees, except to employees of a subcontractor who has secured such payment.

(c) A contractor shall ~~may~~ require a subcontractor to provide evidence of workers' compensation insurance ~~or a copy of his or her certificate of elec-~~

tion. A subcontractor who is a corporation and has an officer who elects electing to be exempt as permitted under this chapter a sole proprietor, partner, or officer of a corporation shall provide a copy of his or her certificate of exemption election to the contractor.

(d)1. If a contractor becomes liable for the payment of compensation to the employees of a subcontractor who has failed to secure such payment in violation of s. 440.38, the contractor or other third-party payor shall be entitled to recover from the subcontractor all benefits paid or payable plus interest unless the contractor and subcontractor have agreed in writing that the contractor will provide coverage.

2. If a contractor or third-party payor becomes liable for the payment of compensation to the corporate officer employee of a subcontractor who is actively engaged in the construction industry and has elected to be exempt from the provisions of this chapter, but whose election is invalid, the contractor or third-party payor may recover from the claimant, partnership, or corporation all benefits paid or payable plus interest, unless the contractor and the subcontractor have agreed in writing that the contractor will provide coverage.

(e) A subcontractor providing services in conjunction with a contractor on the same project or contract work is not liable for the payment of compensation to the employees of another subcontractor or the contractor on such contract work and is ~~not~~ protected by the exclusiveness-of-liability provisions of s. 440.11 from any action at law or in admiralty on account of injury to an of such employee of another subcontractor, or of the contractor, provided that:

1. The subcontractor has secured workers' compensation insurance for its employees or the contractor has secured such insurance on behalf of the subcontractor and its employees in accordance with paragraph (b); and

2. The subcontractor's own gross negligence was not the major contributing cause of the injury.

(f) If an employer fails to secure compensation as required by this chapter, the department shall may assess against the employer a penalty not to exceed \$5,000 for each employee of that employer who is classified by the employer as an independent contractor but who is found by the department to not meet the criteria for an independent contractor that are set forth in s. 440.02. The division shall adopt rules to administer the provisions of this paragraph.

(g) Subject to s. 440.38, any employer who has employees engaged in work in this state shall obtain a Florida policy or endorsement for such employees which utilizes Florida class codes, rates, rules, and manuals that are in compliance with and approved under the provisions of this chapter and the Florida Insurance Code. Failure to comply with this paragraph is a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. The department shall adopt rules for construction industry and nonconstruction-industry employers with regard to the activi-

ties that define what constitutes being “engaged in work” in this state, using the following standards:

1. For employees of nonconstruction-industry employers who have their headquarters outside of Florida and also operate in Florida and who are routinely crossing state lines, but usually return to their homes each night, the employee shall be assigned to the headquarters’ state. However, the construction industry employees performing new construction or alterations in Florida shall be assigned to Florida even if the employees return to their home state each night.

2. The payroll of executive supervisors who may visit a Florida location but who are not in direct charge of a Florida location shall be assigned to the state in which the headquarters is located.

3. For construction contractors who maintain a permanent staff of employees and superintendents, if any of these employees or superintendents are assigned to a job that is located in Florida, either for the duration of the job or any portion thereof, their payroll shall be assigned to Florida rather than the headquarters’ state.

4. Employees who are hired for a specific project in Florida shall be assigned to Florida. For purposes of this section, a person is conclusively presumed to be an independent contractor if:

1. The independent contractor provides the general contractor with an affidavit stating that he or she meets all the requirements of s. 440.02; and

2. The independent contractor provides the general contractor with a valid certificate of workers’ compensation insurance or a valid certificate of exemption issued by the department.

~~A sole proprietor, partner, or officer of a corporation who elects exemption from this chapter by filing a certificate of election under s. 440.05 may not recover benefits or compensation under this chapter. An independent contractor who provides the general contractor with both an affidavit stating that he or she meets the requirements of s. 440.02 and a certificate of exemption is not an employee under s. 440.02 and may not recover benefits under this chapter. For purposes of determining the appropriate premium for workers’ compensation coverage, carriers may not consider any person who meets the requirements of this paragraph to be an employee.~~

Section 9. Section 440.1025, Florida Statutes, is amended to read:

440.1025 ~~Consideration of public~~ Employer workplace safety program in rate-setting; program requirements; rulemaking.—

(1) For a public or private employer to be eligible for receipt of specific identifiable consideration under s. 627.0915 for a workplace safety program in the setting of rates, the ~~public~~ employer must have a workplace safety program. At a minimum, the program must include a written safety policy and safety rules, and make provision for safety inspections, preventative

maintenance, safety training, first-aid, accident investigation, and necessary recordkeeping. For purposes of this section, “public employer” means ~~any agency within state, county, or municipal government employing individuals for salary, wages, or other remuneration.~~ The division may adopt ~~promulgate~~ rules for insurers to utilize in determining public employer compliance with the requirements of this section.

(2) The division shall publicize on the Internet, and shall encourage insurers to publicize, the availability of free safety consultation services and safety program resources.

Section 10. Section 440.103, Florida Statutes, is amended to read:

440.103 Building permits; identification of minimum premium policy.— ~~Except as otherwise provided in this chapter,~~ Every employer shall, as a condition to applying for and receiving a building permit, show proof and certify to the permit issuer that it has secured compensation for its employees under this chapter as provided in ss. 440.10 and 440.38. Such proof of compensation must be evidenced by a certificate of coverage issued by the carrier, a valid exemption certificate approved by the department ~~or the former Division of Workers’ Compensation of the Department of Labor and Employment Security,~~ or a copy of the employer’s authority to self-insure and shall be presented each time the employer applies for a building permit. As provided in s. 627.413(5), each certificate of coverage must show, on its face, whether or not coverage is secured under the minimum premium provisions of rules adopted by rating organizations licensed by the department. The words “minimum premium policy” or equivalent language shall be typed, printed, stamped, or legibly handwritten.

Section 11. Section 440.105, Florida Statutes, is amended to read:

440.105 Prohibited activities; reports; penalties; limitations.—

(1)(a) Any insurance carrier, any individual self-insured, any commercial or group self-insurance fund, any professional practitioner licensed or regulated by the Department of Health Business and Professional Regulation, except as otherwise provided by law, any medical review committee as defined in s. 766.101, any private medical review committee, and any insurer, agent, or other person licensed under the insurance code, or any employee thereof, having knowledge or who believes that a fraudulent act or any other act or practice which, upon conviction, constitutes a felony or misdemeanor under this chapter is being or has been committed shall send to the Division of Insurance Fraud, Bureau of Workers’ Compensation Fraud, a report or information pertinent to such knowledge or belief and such additional information relative thereto as the bureau may require. The bureau shall review such information or reports and select such information or reports as, in its judgment, may require further investigation. It shall then cause an independent examination of the facts surrounding such information or report to be made to determine the extent, if any, to which a fraudulent act or any other act or practice which, upon conviction, constitutes a felony or a misdemeanor under this chapter is being committed. The bureau shall report any alleged violations of law which its investigations disclose to the appropriate licensing agency and state attorney or other prosecuting agency

having jurisdiction with respect to any such violations of this chapter. If prosecution by the state attorney or other prosecuting agency having jurisdiction with respect to such violation is not begun within 60 days of the bureau's report, the state attorney or other prosecuting agency having jurisdiction with respect to such violation shall inform the bureau of the reasons for the lack of prosecution.

(b) In the absence of fraud or bad faith, a person is not subject to civil liability for libel, slander, or any other relevant tort by virtue of filing reports, without malice, or furnishing other information, without malice, required by this section or required by the bureau, and no civil cause of action of any nature shall arise against such person:

1. For any information relating to suspected fraudulent acts furnished to or received from law enforcement officials, their agents, or employees;
2. For any information relating to suspected fraudulent acts furnished to or received from other persons subject to the provisions of this chapter; or
3. For any such information relating to suspected fraudulent acts furnished in reports to the bureau, or the National Association of Insurance Commissioners.

(2) Whoever violates any provision of this subsection commits a misdemeanor of the first ~~second~~ degree, punishable as provided in s. 775.082 or s. 775.083.

(a) It shall be unlawful for any employer to knowingly:

1. Coerce or attempt to coerce, as a precondition to employment or otherwise, an employee to obtain a certificate of election of exemption pursuant to s. 440.05.
2. Discharge or refuse to hire an employee or job applicant because the employee or applicant has filed a claim for benefits under this chapter.
3. Discharge, discipline, or take any other adverse personnel action against any employee for disclosing information to the department or any law enforcement agency relating to any violation or suspected violation of any of the provisions of this chapter or rules promulgated hereunder.
4. Violate a stop-work order issued by the department pursuant to s. 440.107.

(b) It shall be unlawful for any insurance entity to revoke or cancel a workers' compensation insurance policy or membership because an employer has returned an employee to work or hired an employee who has filed a workers' compensation claim.

(3) Whoever violates any provision of this subsection commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(a) It shall be unlawful for any employer to knowingly fail to update applications for coverage as required by s. 440.381(1) and department of ~~Insurance~~ rules within 7 days after the reporting date for any change in the required information, or to post notice of coverage pursuant to s. 440.40.

(b) It shall be unlawful for any employer to knowingly participate in the creation of the employment relationship in which the employee has used any false, fraudulent, or misleading oral or written statement as evidence of identity.

~~(c)~~(b) It is unlawful for any attorney or other person, in his or her individual capacity or in his or her capacity as a public or private employee, or for any firm, corporation, partnership, or association to receive any fee or other consideration or any gratuity from a person on account of services rendered for a person in connection with any proceedings arising under this chapter, unless such fee, consideration, or gratuity is approved by a judge of compensation claims or by the Deputy Chief Judge of Compensation Claims.

(4) Whoever violates any provision of this subsection commits insurance fraud, punishable as provided in paragraph (f).

(a) It shall be unlawful for any employer to knowingly:

1. Present or cause to be presented any false, fraudulent, or misleading oral or written statement to any person as evidence of compliance with s. 440.38.

2. Make a deduction from the pay of any employee entitled to the benefits of this chapter for the purpose of requiring the employee to pay any portion of premium paid by the employer to a carrier or to contribute to a benefit fund or department maintained by such employer for the purpose of providing compensation or medical services and supplies as required by this chapter.

3. Fail to secure payment of compensation if required to do so by this chapter.

(b) It shall be unlawful for any person:

1. To knowingly make, or cause to be made, any false, fraudulent, or misleading oral or written statement for the purpose of obtaining or denying any benefit or payment under this chapter.

2. To present or cause to be presented any written or oral statement as part of, or in support of, a claim for payment or other benefit pursuant to any provision of this chapter, knowing that such statement contains any false, incomplete, or misleading information concerning any fact or thing material to such claim.

3. To prepare or cause to be prepared any written or oral statement that is intended to be presented to any employer, insurance company, or self-insured program in connection with, or in support of, any claim for payment or other benefit pursuant to any provision of this chapter, knowing that such

statement contains any false, incomplete, or misleading information concerning any fact or thing material to such claim.

4. To knowingly assist, conspire with, or urge any person to engage in activity prohibited by this section.

5. To knowingly make any false, fraudulent, or misleading oral or written statement, or to knowingly omit or conceal material information, required by s. 440.185 or s. 440.381, for the purpose of obtaining workers' compensation coverage or for the purpose of avoiding, delaying, or diminishing the amount of payment of any workers' compensation premiums.

6. To knowingly misrepresent or conceal payroll, classification of workers, or information regarding an employer's loss history which would be material to the computation and application of an experience rating modification factor for the purpose of avoiding or diminishing the amount of payment of any workers' compensation premiums.

7. To knowingly present or cause to be presented any false, fraudulent, or misleading oral or written statement to any person as evidence of compliance with s. 440.38, as evidence of eligibility for a certificate of exemption under s. 440.05.

8. To knowingly violate a stop-work order issued by the department pursuant to s. 440.107.

9. To knowingly present or cause to be presented any false, fraudulent, or misleading oral or written statement to any person as evidence of identity for the purpose of obtaining employment or filing or supporting a claim for workers' compensation benefits.

(c) It shall be unlawful for any physician licensed under chapter 458, osteopathic physician licensed under chapter 459, chiropractic physician licensed under chapter 460, podiatric physician licensed under chapter 461, optometric physician licensed under chapter 463, or any other practitioner licensed under the laws of this state to knowingly and willfully assist, conspire with, or urge any person to fraudulently violate any of the provisions of this chapter.

(d) It shall be unlawful for any person or governmental entity licensed under chapter 395 to maintain or operate a hospital in such a manner so that such person or governmental entity knowingly and willfully allows the use of the facilities of such hospital by any person, in a scheme or conspiracy to fraudulently violate any of the provisions of this chapter.

(e) It shall be unlawful for any attorney or other person, in his or her individual capacity or in his or her capacity as a public or private employee, or any firm, corporation, partnership, or association, to knowingly assist, conspire with, or urge any person to fraudulently violate any of the provisions of this chapter.

(f) If the monetary value amount of any ~~claim or workers' compensation insurance premium involved in~~ any violation of this subsection:

1. Is less than \$20,000, the offender commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

2. Is \$20,000 or more, but less than \$100,000, the offender commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

3. Is \$100,000 or more, the offender commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(5) It shall be unlawful for any attorney or other person, in his or her individual capacity or in his or her capacity as a public or private employee or for any firm, corporation, partnership, or association, to unlawfully solicit any business in and about city or county hospitals, courts, or any public institution or public place; in and about private hospitals or sanitariums; in and about any private institution; or upon private property of any character whatsoever for the purpose of making workers' compensation claims. Whoever violates any provision of this subsection commits a felony of the second ~~third~~ degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.085.

(6) This section shall not be construed to preclude the applicability of any other provision of criminal law that applies or may apply to any transaction.

~~(7) For the purpose of the section, the term "statement" includes, but is not limited to, any notice, representation, statement, proof of injury, bill for services, diagnosis, prescription, hospital or doctor records, X ray, test result, or other evidence of loss, injury, or expense.~~

(7)(8) An injured employee or any other party making a claim under this chapter shall provide his or her personal signature attesting that he or she has reviewed, understands, and acknowledges All claim forms as provided for in this chapter shall contain a notice that clearly states in substance the following statement: "Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in s. 817.234." If the injured employee or other party refuses to sign the document attesting Each claimant shall personally sign the claim form and attest that he or she has reviewed, understands, and acknowledges the statement, benefits or payments under this chapter shall be suspended until such signature is obtained foregoing notice.

Section 12. Subsection (3) of section 440.1051, Florida Statutes, is amended to read:

440.1051 Fraud reports; civil immunity; criminal penalties.—

(2) Any person who reports workers' compensation fraud to the division under subsection (1) is immune from civil liability for doing so, and the person or entity alleged to have committed the fraud may not retaliate against him or her for providing such report, unless the person making the report knows it to be false.

(3) A person who calls and, knowingly and falsely, reports workers' compensation fraud or who, in violation of subsection (2) retaliates against a person for making such report, ~~commits is guilty of a felony misdemeanor of the third first degree, punishable as provided in s. 775.082, or s. 775.083, or s. 775.084 both.~~

Section 13. Section 440.107, Florida Statutes, is amended to read:

440.107 Department powers to enforce employer compliance with coverage requirements.—

(1) The Legislature finds that the failure of an employer to comply with the workers' compensation coverage requirements under this chapter poses an immediate danger to public health, safety, and welfare. ~~The Legislature authorizes the department to secure employer compliance with the workers' compensation coverage requirements and authorizes the department to conduct investigations for the purpose of ensuring employer compliance.~~

(2) ~~For the purposes of this section, "securing the payment of workers' compensation" means obtaining coverage that meets the requirements of this chapter and the Florida Insurance Code. However, if at any time an employer materially understates or conceals payroll, materially misrepresents or conceals employee duties so as to avoid proper classification for premium calculations, or materially misrepresents or conceals information pertinent to the computation and application of an experience rating modification factor, such employer shall be deemed to have failed to secure payment of workers' compensation and shall be subject to the sanctions set forth in this section. A stop-work order issued because an employer is deemed to have failed to secure the payment of workers' compensation required under this chapter because the employer has materially understated or concealed payroll, materially misrepresented or concealed employee duties so as to avoid proper classification for premium calculations, or materially misrepresented or concealed information pertinent to the computation and application of an experience rating modification factor shall have no effect upon an employer's or carrier's duty to provide benefits under this chapter or upon any of the employer's or carrier's rights and defenses under this chapter, including exclusive remedy. The department and its authorized representatives may enter and inspect any place of business at any reasonable time for the limited purpose of investigating compliance with workers' compensation coverage requirements under this chapter. Each employer shall keep true and accurate business records that contain such information as the department prescribes by rule. The business records must contain information necessary for the department to determine compliance with workers' compensation coverage requirements and must be maintained within this state by the business, in such a manner as to be accessible within a reasonable time upon request by the department. The business records must be open to inspection and be available for copying by the department at any reasonable time and place and as often as necessary. The department may require from any employer any sworn or unsworn reports, pertaining to persons employed by that employer, deemed necessary for the effective administration of the workers' compensation coverage requirements.~~

(3) The department shall enforce workers' compensation coverage requirements, including the requirement that the employer secure the payment of workers' compensation, and the requirement that the employer provide the carrier with information to accurately determine payroll and correctly assign classification codes. In addition to any other powers under this chapter, the department shall have the power to:

(a) Conduct investigations for the purpose of ensuring employer compliance.

(b) Enter and inspect any place of business at any reasonable time for the purpose of investigating employer compliance.

(c) Examine and copy business records.

(d) Administer oaths and affirmations.

(e) Certify to official acts.

(f) Issue and serve subpoenas for attendance of witnesses or production of business records, books, papers, correspondence, memoranda, and other records.

(g) Issue stop-work orders, penalty assessment orders, and any other orders necessary for the administration of this section.

(h) Enforce the terms of a stop-work order.

(i) Levy and pursue actions to recover penalties.

~~(j) Seek injunctions and other appropriate relief. In discharging its duties, the department may administer oaths and affirmations, certify to official acts, issue subpoenas to compel the attendance of witnesses and the production of books, papers, correspondence, memoranda, and other records deemed necessary by the department as evidence in order to ensure proper compliance with the coverage provisions of this chapter.~~

(4) The department shall designate representatives who may serve subpoenas and other process of the department issued under this section.

(5) The department shall specify by rule the business records that employers must maintain and produce to comply with this section.

(6)(4) If a person has refused to obey a subpoena to appear before the department or its authorized representative or ~~and~~ produce evidence requested by the department or to give testimony about the matter that is under investigation, a court has jurisdiction to issue an order requiring compliance with the subpoena if the court has jurisdiction in the geographical area where the inquiry is being carried on or in the area where the person who has refused the subpoena is found, resides, or transacts business. Failure to obey such a court order may be punished by the court as contempt, either civilly or criminally. Costs, including reasonable attorney's fees, incurred by the department to obtain an order granting, in whole or in part,

a petition to enforce a subpoena or a subpoena duces tecum shall be taxed against the subpoenaed party.

(7)(a)(5) Whenever the department determines that an employer who is required to secure the payment to his or her employees of the compensation provided for by this chapter has failed to secure the payment of workers' compensation required by this chapter or to produce the required business records under subsection (5) within 5 business days after receipt of the written request of the department do so, such failure shall be deemed an immediate serious danger to public health, safety, or welfare sufficient to justify service by the department of a stop-work order on the employer, requiring the cessation of all business operations at the place of employment or job site. If the department ~~division~~ makes such a determination, the ~~department~~ division shall issue a stop-work order within 72 hours. The order shall take effect when served upon the date of service upon the employer or, for a particular employer work site, when served at that work site, ~~unless the employer provides evidence satisfactory to the department of having secured any necessary insurance or self-insurance and pays a civil penalty to the department, to be deposited by the department into the Workers' Compensation Administration Trust Fund, in the amount of \$100 per day for each day the employer was not in compliance with this chapter.~~ In addition to serving a stop-work order at a particular work site which shall be effective immediately, the department shall immediately proceed with service upon the employer which shall be effective upon all employer work sites in the state for which the employer is not in compliance. A stop-work order may be served with regard to an employer's work site by posting a copy of the stop-work order in a conspicuous location at the work site. The order shall remain in effect until the department issues an order releasing the stop-work order upon a finding that the employer has come into compliance with the coverage requirements of this chapter and has paid any penalty assessed under this section. The department may require an employer who is found to have failed to comply with the coverage requirements of s. 440.38 to file with the department, as a condition of release from a stop-work order, periodic reports for a probationary period that shall not exceed 2 years that demonstrate the employer's continued compliance with this chapter. The department shall by rule specify the reports required and the time for filing under this subsection.

(b) Stop-work orders and penalty assessment orders issued under this section against a corporation, partnership, or sole proprietorship shall be in effect against any successor corporation or business entity that has one or more of the same principals or officers as the corporation or partnership against which the stop-work order was issued and are engaged in the same or equivalent trade or activity.

(c) The department shall assess a penalty of \$1,000 per day against an employer for each day that the employer conducts business operations that are in violation of a stop-work order.

(d)1. In addition to any penalty, stop-work order, or injunction, the department shall assess against any employer who has failed to secure the payment of compensation as required by this chapter a penalty equal to 1.5

times the amount the employer would have paid in premium when applying approved manual rates to the employer's payroll during periods for which it failed to secure the payment of workers' compensation required by this chapter within the preceding 3-year period or \$1,000, whichever is greater.

2. Any subsequent violation within 5 years after the most recent violation shall, in addition to the penalties set forth in this subsection, be deemed a knowing act within the meaning of s. 440.105.

(e) When an employer fails to provide business records sufficient to enable the department to determine the employer's payroll for the period requested for the calculation of the penalty provided in paragraph (d), for penalty calculation purposes, the imputed weekly payroll for each employee, corporate officer, sole proprietor, or partner shall be the statewide average weekly wage as defined in s. 440.12(2) multiplied by 1.5.

(f) In addition to any other penalties provided for in this chapter, the department may assess against the employer a penalty of \$5,000 for each employee of that employer who the employer represents to the department or carrier as an independent contractor but who is determined by the department not to be an independent contractor as defined in s. 440.02.

(8)(6) In addition to the issuance of a stop-work order under subsection (7), the department may file a complaint in the circuit court in and for Leon County to enjoin any employer, who has failed to secure the payment of workers' compensation as required by this chapter, from employing individuals and from conducting business until the employer presents evidence satisfactory to the department of having secured the payment of workers' compensation required by this chapter and pays a civil penalty assessed by the department under this section, to be deposited by the department into the Workers' Compensation Administration Trust Fund, in the amount of \$100 per day for each day the employer was not in compliance with this chapter.

(9)(7) In addition to any penalty, stop-work order, or injunction, the department shall assess against any employer, who has failed to secure the payment of compensation as required by this chapter, a penalty in the following amount:

(a) An amount equal to at least the amount that the employer would have paid or up to twice the amount the employer would have paid during periods it illegally failed to secure payment of compensation in the preceding 3-year period based on the employer's payroll during the preceding 3-year period; or

(b) One thousand dollars, whichever is greater. Any penalty assessed under this subsection is due within 30 days after the date on which the employer is notified, except that, if the department has posted a stop-work order or obtained injunctive relief against the employer, payment is due, in addition to those conditions set forth in this section, as a condition to relief from a stop-work order or an injunction. Interest shall accrue on amounts not paid when due at the rate of 1 percent per month. The department division shall adopt rules to administer this section.

(10)(8) The department may bring an action in circuit court to recover penalties assessed under this section, including any interest owed to the department pursuant to this section. In any action brought by the department pursuant to this section in which it prevails, the circuit court shall award costs, including the reasonable costs of investigation and a reasonable attorney's fee.

(11)(9) Any judgment obtained by the department and any penalty due pursuant to the service of a stop-work order or otherwise due under this section shall, until collected, constitute a lien upon the entire interest of the employer, legal or equitable, in any property, real or personal, tangible or intangible; however, such lien is subordinate to claims for unpaid wages and any prior recorded liens, and a lien created by this section is not valid against any person who, subsequent to such lien and in good faith and for value, purchases real or personal property from such employer or becomes the mortgagee on real or personal property of such employer, or against a subsequent attaching creditor, unless, with respect to real estate of the employer, a notice of the lien is recorded in the public records of the county where the real estate is located, and with respect to personal property of the employer, the notice is recorded with the Secretary of State.

(12)(10) Any law enforcement agency in the state may, at the request of the department, render any assistance necessary to carry out the provisions of this section, including, but not limited to, preventing any employee or other person from remaining at a place of employment or job site after a stop-work order or injunction has taken effect.

(13)(11) Agency action Actions by the department under this section, if contested, must be contested as provided in chapter 120. All civil penalties assessed by the department must be paid into the Workers' Compensation Administration Trust Fund. ~~The department shall return any sums previously paid, upon conclusion of an action, if the department fails to prevail and if so directed by an order of court or an administrative hearing officer. The requirements of this subsection may be met by posting a bond in an amount equal to twice the penalty and in a form approved by the department.~~

(14)(12) If the department ~~division~~ finds that an employer who is certified or registered under part I or part II of chapter 489 and who is required to secure the payment of workers' ~~the~~ compensation under ~~provided for by~~ this chapter to his or her employees has failed to do so, the department ~~division~~ shall immediately notify the Department of Business and Professional Regulation.

Section 14. Subsections (1) and (3) of section 440.11, Florida Statutes, are amended to read:

440.11 Exclusiveness of liability.—

(1) The liability of an employer prescribed in s. 440.10 shall be exclusive and in place of all other liability, including vicarious liability, of such employer to any third-party tortfeasor and to the employee, the legal representative thereof, husband or wife, parents, dependents, next of kin, and anyone

otherwise entitled to recover damages from such employer at law or in admiralty on account of such injury or death, except as follows: ~~that~~

(a) If an employer fails to secure payment of compensation as required by this chapter, an injured employee, or the legal representative thereof in case death results from the injury, may elect to claim compensation under this chapter or to maintain an action at law or in admiralty for damages on account of such injury or death. In such action the defendant may not plead as a defense that the injury was caused by negligence of a fellow employee, that the employee assumed the risk of the employment, or that the injury was due to the comparative negligence of the employee.

(b) When an employer commits an intentional tort that causes the injury or death of the employee. For purposes of this paragraph, an employer's actions shall be deemed to constitute an intentional tort and not an accident only when the employee proves, by clear and convincing evidence, that:

1. The employer deliberately intended to injure the employee; or

2. The employer engaged in conduct that the employer knew, based on prior similar accidents or on explicit warnings specifically identifying a known danger, was virtually certain to result in injury or death to the employee, and the employee was not aware of the risk because the danger was not apparent and the employer deliberately concealed or misrepresented the danger so as to prevent the employee from exercising informed judgment about whether to perform the work.

The same immunities from liability enjoyed by an employer shall extend as well to each employee of the employer when such employee is acting in furtherance of the employer's business and the injured employee is entitled to receive benefits under this chapter. Such fellow-employee immunities shall not be applicable to an employee who acts, with respect to a fellow employee, with willful and wanton disregard or unprovoked physical aggression or with gross negligence when such acts result in injury or death or such acts proximately cause such injury or death, nor shall such immunities be applicable to employees of the same employer when each is operating in the furtherance of the employer's business but they are assigned primarily to unrelated works within private or public employment. The same immunity provisions enjoyed by an employer shall also apply to any sole proprietor, partner, corporate officer or director, supervisor, or other person who in the course and scope of his or her duties acts in a managerial or policymaking capacity and the conduct which caused the alleged injury arose within the course and scope of said managerial or policymaking duties and was not a violation of a law, whether or not a violation was charged, for which the maximum penalty which may be imposed does not exceed 60 days' imprisonment as set forth in s. 775.082. The immunity from liability provided in this subsection extends to county governments with respect to employees of county constitutional officers whose offices are funded by the board of county commissioners.

(3) An employer's workers' compensation carrier, service agent, or safety consultant shall not be liable as a third-party tortfeasor to employees of the

employer or employees of its subcontractors for assisting the employer and its subcontractors, if any, in carrying out the employer's rights and responsibilities under this chapter by furnishing any safety inspection, safety consultative service, or other safety service incidental to the workers' compensation or employers' liability coverage or to the workers' compensation or employer's liability servicing contract. Without limitation, a safety consultant may include an owner, as defined in chapter 713, or an owner's related, affiliated, or subsidiary companies and the employees of each. The exclusion from liability under this subsection shall not apply in any case in which injury or death is proximately caused by the willful and unprovoked physical aggression, or by the negligent operation of a motor vehicle, by employees, officers, or directors of the employer's workers' compensation carrier, service agent, or safety consultant.

Section 15. Section 440.13, Florida Statutes, is amended to read:

440.13 Medical services and supplies; penalty for violations; limitations.—

(1) DEFINITIONS.—As used in this section, the term:

(a) “Alternate medical care” means a change in treatment or health care provider.

(b) “Attendant care” means care rendered by trained professional attendants which is beyond the scope of household duties. Family members may provide nonprofessional attendant care, but may not be compensated under this chapter for care that falls within the scope of household duties and other services normally and gratuitously provided by family members. “Family member” means a spouse, father, mother, brother, sister, child, grandchild, father-in-law, mother-in-law, aunt, or uncle.

(c) “Carrier” means, for purposes of this section, insurance carrier, self-insurance fund or individually self-insured employer, or assessable mutual insurer.

~~(d) “Catastrophic injury” means an injury as defined in s. 440.02.~~

~~(d)(e)~~ “Certified health care provider” means a health care provider who has been certified by the agency or who has entered an agreement with a licensed managed care organization to provide treatment to injured workers under this section. Certification of such health care provider must include documentation that the health care provider has read and is familiar with the portions of the statute, impairment guides, practice parameters, protocols of treatment, and rules which govern the provision of remedial treatment, care, and attendance.

~~(e)(f)~~ “Compensable” means a determination by a carrier or judge of compensation claims that a condition suffered by an employee results from an injury arising out of and in the course of employment.

~~(f)(g)~~ “Emergency services and care” means emergency services and care as defined in s. 395.002.

(g)(h) “Health care facility” means any hospital licensed under chapter 395 and any health care institution licensed under chapter 400.

(h)(i) “Health care provider” means a physician or any recognized practitioner who provides skilled services pursuant to a prescription or under the supervision or direction of a physician and who has been certified by the agency as a health care provider. The term “health care provider” includes a health care facility.

(i)(j) “Independent medical examiner” means a physician selected by either an employee or a carrier to render one or more independent medical examinations in connection with a dispute arising under this chapter.

(j)(k) “Independent medical examination” means an objective evaluation of the injured employee’s medical condition, including, but not limited to, impairment or work status, performed by a physician or an expert medical advisor at the request of a party, a judge of compensation claims, or the agency to assist in the resolution of a dispute arising under this chapter.

(k)(l) “Instance of overutilization” means a specific inappropriate service or level of service provided to an injured employee that includes the provision of treatment in excess of established practice parameters and protocols of treatment established in accordance with this chapter.

(l)(m) “Medically necessary” or “medical necessity” means any medical service or medical supply which is used to identify or treat an illness or injury, is appropriate to the patient’s diagnosis and status of recovery, and is consistent with the location of service, the level of care provided, and applicable practice parameters. The service should be widely accepted among practicing health care providers, based on scientific criteria, and determined to be reasonably safe. The service must not be of an experimental, investigative, or research nature, ~~except in those instances in which prior approval of the Agency for Health Care Administration has been obtained. The Agency for Health Care Administration shall adopt rules providing for such approval on a case-by-case basis when the service or supply is shown to have significant benefits to the recovery and well-being of the patient.~~

(m)(n) “Medicine” means a drug prescribed by an authorized health care provider and includes only generic drugs or single-source patented drugs for which there is no generic equivalent, unless the authorized health care provider writes or states that the brand-name drug as defined in s. 465.025 is medically necessary, or is a drug appearing on the schedule of drugs created pursuant to s. 465.025(6), or is available at a cost lower than its generic equivalent.

(n)(o) “Palliative care” means noncurative medical services that mitigate the conditions, effects, or pain of an injury.

(o)(p) “Pattern or practice of overutilization” means repetition of instances of overutilization within a specific medical case or multiple cases by a single health care provider.

(p)(q) “Peer review” means an evaluation by two or more physicians licensed under the same authority and with the same or similar specialty as the physician under review, of the appropriateness, quality, and cost of health care and health services provided to a patient, based on medically accepted standards.

(q)(r) “Physician” or “doctor” means a physician licensed under chapter 458, an osteopathic physician licensed under chapter 459, a chiropractic physician licensed under chapter 460, a podiatric physician licensed under chapter 461, an optometrist licensed under chapter 463, or a dentist licensed under chapter 466, each of whom must be certified by the agency as a health care provider.

(r)(s) “Reimbursement dispute” means any disagreement between a health care provider or health care facility and carrier concerning payment for medical treatment.

(s)(t) “Utilization control” means a systematic process of implementing measures that assure overall management and cost containment of services delivered, including compliance with practice parameters and protocols of treatment as provided for in this chapter.

(t)(u) “Utilization review” means the evaluation of the appropriateness of both the level and the quality of health care and health services provided to a patient, including, but not limited to, evaluation of the appropriateness of treatment, hospitalization, or office visits based on medically accepted standards. Such evaluation must be accomplished by means of a system that identifies the utilization of medical services based on practice parameters and protocols of treatment as provided for in this chapter ~~medically accepted standards as established by medical consultants with qualifications similar to those providing the care under review, and that refers patterns and practices of overutilization to the agency.~~

(2) MEDICAL TREATMENT; DUTY OF EMPLOYER TO FURNISH.—

(a) Subject to the limitations specified elsewhere in this chapter, the employer shall furnish to the employee such medically necessary remedial treatment, care, and attendance for such period as the nature of the injury or the process of recovery may require, which is in accordance with established practice parameters and protocols of treatment as provided for in this chapter, including medicines, medical supplies, durable medical equipment, orthoses, prostheses, and other medically necessary apparatus. Remedial treatment, care, and attendance, including work-hardening programs or pain-management programs accredited by the Commission on Accreditation of Rehabilitation Facilities or Joint Commission on the Accreditation of Health Organizations or pain-management programs affiliated with medical schools, shall be considered as covered treatment only when such care is given based on a referral by a physician as defined in this chapter. ~~Each facility shall maintain outcome data, including work status at discharges, total program charges, total number of visits, and length of stay. The department shall utilize such data and report to the President of the Senate and the Speaker of the House of Representatives regarding the efficacy and cost-effectiveness of such program, no later than October 1, 1994. Medically~~

necessary treatment, care, and attendance does not include chiropractic services in excess of ~~24~~ ¹⁸ treatments or rendered ~~12~~ ⁸ weeks beyond the date of the initial chiropractic treatment, whichever comes first, unless the carrier authorizes additional treatment or the employee is catastrophically injured.

(b) The employer shall provide appropriate professional or nonprofessional attendant care performed only at the direction and control of a physician when such care is medically necessary. The physician shall prescribe such care in writing. The employer or carrier shall not be responsible for such care until the prescription for attendant care is received by the employer and carrier, which shall specify the time periods for such care, the level of care required, and the type of assistance required. A prescription for attendant care shall not prescribe such care retroactively. The value of nonprofessional attendant care provided by a family member must be determined as follows:

1. If the family member is not employed or if the family member is employed and is providing attendant care services during hours that he or she is not engaged in employment, the per-hour value equals the federal minimum hourly wage.

2. If the family member is employed and elects to leave that employment to provide attendant or custodial care, the per-hour value of that care equals the per-hour value of the family member's former employment, not to exceed the per-hour value of such care available in the community at large. A family member or a combination of family members providing nonprofessional attendant care under this paragraph may not be compensated for more than a total of 12 hours per day.

3. If the family member remains employed while providing attendant or custodial care, the per-hour value of that care equals the per-hour value of the family member's employment, not to exceed the per-hour value of such care available in the community at large.

(c) If the employer fails to provide initial treatment or care required by this section after request by the injured employee, the employee may obtain such initial treatment at the expense of the employer, if the initial treatment or care is compensable and medically necessary and is in accordance with established practice parameters and protocols of treatment as provided for in this chapter. There must be a specific request for the initial treatment or care, and the employer or carrier must be given a reasonable time period within which to provide the initial treatment or care. However, the employee is not entitled to recover any amount personally expended for the initial treatment or care service unless he or she has requested the employer to furnish that initial treatment or service and the employer has failed, refused, or neglected to do so within a reasonable time or unless the nature of the injury requires such initial treatment, nursing, and services and the employer or his or her superintendent or foreman, having knowledge of the injury, has neglected to provide the initial treatment or care service.

(d) The carrier has the right to transfer the care of an injured employee from the attending health care provider if an independent medical examina-

tion determines that the employee is not making appropriate progress in recuperation.

(e) Except in emergency situations and for treatment rendered by a managed care arrangement, after any initial examination and diagnosis by a physician providing remedial treatment, care, and attendance, and before a proposed course of medical treatment begins, each insurer shall review, in accordance with the requirements of this chapter, the proposed course of treatment, to determine whether such treatment would be recognized as reasonably prudent. The review must be in accordance with all applicable workers' compensation practice parameters and protocols of treatment established in accordance with this chapter. The insurer must accept any such proposed course of treatment unless the insurer notifies the physician of its specific objections to the proposed course of treatment by the close of the tenth business day after notification by the physician, or a supervised designee of the physician, of the proposed course of treatment.

(f) Upon the written request of the employee, the carrier shall give the employee the opportunity for one change of physician during the course of treatment for any one accident. Upon the granting of a change of physician, the originally authorized physician in the same specialty as the changed physician shall become deauthorized upon written notification by the employer or carrier. The carrier shall authorize an alternative physician who shall not be professionally affiliated with the previous physician within 5 days after receipt of the request. If the carrier fails to provide a change of physician as requested by the employee, the employee may select the physician and such physician shall be considered authorized if the treatment being provided is compensable and medically necessary.

~~Failure of the carrier to timely comply with this subsection shall be a violation of this chapter and the carrier shall be subject to penalties as provided for in s. 440.525. The employee shall be entitled to select another physician from among not fewer than three carrier-authorized physicians who are not professionally affiliated.~~

(3) PROVIDER ELIGIBILITY; AUTHORIZATION.—

(a) As a condition to eligibility for payment under this chapter, a health care provider who renders services must be a certified health care provider and must receive authorization from the carrier before providing treatment. This paragraph does not apply to emergency care. The agency shall adopt rules to implement the certification of health care providers.

(b) A health care provider who renders emergency care must notify the carrier by the close of the third business day after it has rendered such care. If the emergency care results in admission of the employee to a health care facility, the health care provider must notify the carrier by telephone within 24 hours after initial treatment. Emergency care is not compensable under this chapter unless the injury requiring emergency care arose as a result of a work-related accident. Pursuant to chapter 395, all licensed physicians and health care providers in this state shall be required to make their services available for emergency treatment of any employee eligible for

workers' compensation benefits. To refuse to make such treatment available is cause for revocation of a license.

(c) A health care provider may not refer the employee to another health care provider, diagnostic facility, therapy center, or other facility without prior authorization from the carrier, except when emergency care is rendered. Any referral must be to a health care provider that has been certified by the agency, unless the referral is for emergency treatment, and the referral must be made in accordance with practice parameters and protocols of treatment as provided for in this chapter.

(d) A carrier must respond, by telephone or in writing, to a request for authorization from an authorized health care provider by the close of the third business day after receipt of the request. A carrier who fails to respond to a written request for authorization for referral for medical treatment by the close of the third business day after receipt of the request consents to the medical necessity for such treatment. All such requests must be made to the carrier. Notice to the carrier does not include notice to the employer.

(e) Carriers shall adopt procedures for receiving, reviewing, documenting, and responding to requests for authorization. Such procedures shall be for a health care provider certified under this section.

(f) By accepting payment under this chapter for treatment rendered to an injured employee, a health care provider consents to the jurisdiction of the agency as set forth in subsection (11) and to the submission of all records and other information concerning such treatment to the agency in connection with a reimbursement dispute, audit, or review as provided by this section. The health care provider must further agree to comply with any decision of the agency rendered under this section.

(g) The employee is not liable for payment for medical treatment or services provided pursuant to this section except as otherwise provided in this section.

(h) The provisions of s. 456.053 are applicable to referrals among health care providers, as defined in subsection (1), treating injured workers.

(i) Notwithstanding paragraph (d), a claim for specialist consultations, surgical operations, physiotherapeutic or occupational therapy procedures, X-ray examinations, or special diagnostic laboratory tests that cost more than \$1,000 and other specialty services that the agency identifies by rule is not valid and reimbursable unless the services have been expressly authorized by the carrier, or unless the carrier has failed to respond within 10 days to a written request for authorization, or unless emergency care is required. The insurer shall ~~not refuse to~~ authorize such consultation or procedure unless the health care provider or facility is not authorized or certified, unless such treatment is not in accordance with practice parameters and protocols of treatment established in this chapter, or unless a judge of compensation claims an expert medical advisor has determined that the consultation or procedure is not medically necessary, not in accordance with the practice parameters and protocols of treatment established in this chapter, or otherwise not compensable under this chapter. Authorization of a

treatment plan does not constitute express authorization for purposes of this section, except to the extent the carrier provides otherwise in its authorization procedures. This paragraph does not limit the carrier's obligation to identify and disallow overutilization or billing errors.

(j) Notwithstanding anything in this chapter to the contrary, a sick or injured employee shall be entitled, at all times, to free, full, and absolute choice in the selection of the pharmacy or pharmacist dispensing and filling prescriptions for medicines required under this chapter. It is expressly forbidden for the agency, an employer, or a carrier, or any agent or representative of the agency, an employer, or a carrier to select the pharmacy or pharmacist which the sick or injured employee must use; condition coverage or payment on the basis of the pharmacy or pharmacist utilized; or to otherwise interfere in the selection by the sick or injured employee of a pharmacy or pharmacist.

(4) NOTICE OF TREATMENT TO CARRIER; FILING WITH DEPARTMENT.—

(a) Any health care provider providing necessary remedial treatment, care, or attendance to any injured worker shall submit treatment reports to the carrier in a format prescribed by the department ~~in consultation with the agency~~. A claim for medical or surgical treatment is not valid or enforceable against such employer or employee, unless, by the close of the third business day following the first treatment, the physician providing the treatment furnishes to the employer or carrier a preliminary notice of the injury and treatment in a format on forms prescribed by the department ~~in consultation with the agency~~ and, within 15 days thereafter, furnishes to the employer or carrier a complete report, and subsequent thereto furnishes progress reports, if requested by the employer or insurance carrier, at intervals of not less than 3 weeks apart or at less frequent intervals if requested in a format on forms prescribed by the department ~~in consultation with the agency~~.

(b) Upon the request of the department ~~or agency~~, each medical report or bill obtained or received by the employer, the carrier, or the injured employee, or the attorney for the employer, carrier, or injured employee, with respect to the remedial treatment, care, and attendance of the injured employee, including any report of an examination, diagnosis, or disability evaluation, must be produced by the health care provider to filed with the department or agency pursuant to rules adopted by the department ~~in consultation with the agency~~. The health care provider shall also furnish to the injured employee or ~~to his or her attorney~~ and the employer or carrier or its attorney, on demand, a copy of his or her office chart, records, and reports, and may charge the injured employee no more than 50 cents per page for copying the records and the actual direct cost to the health care provider or health care facility for X rays, microfilm, or other nonpaper records an amount authorized by the department for the copies. Each such health care provider shall provide to the ~~agency or department~~ information about the remedial treatment, care, and attendance which the ~~agency or department~~ reasonably requests.

(c) It is the policy for the administration of the workers' compensation system that there shall be reasonable access to medical information by all parties to facilitate the self-executing features of the law. An employee who reports an injury or illness alleged to be work-related waives any physician-patient privilege with respect to any condition or complaint reasonably related to the condition for which the employee claims compensation. Notwithstanding the limitations in s. 456.057 and subject to the limitations in s. 381.004, upon the request of the employer, the carrier, an authorized qualified rehabilitation provider, or the attorney for the employer or carrier, the medical records, reports, and information of an injured employee relevant to the particular injury or illness for which compensation is sought must be furnished to those persons and the medical condition of the injured employee must be discussed with those persons, if the records and the discussions are restricted to conditions relating to the workplace injury. Release of medical information by the health care provider or other physician does not require the authorization of the injured employee. If medical records, reports, and information of an injured employee are sought from health care providers who are not subject to the jurisdiction of the state, the injured employee shall sign an authorization allowing for the employer or carrier to obtain the medical records, reports, or information. Any such discussions or release of information may be held before or after the filing of a claim or petition for benefits without the knowledge, consent, or presence of any other party or his or her agent or representative. A health care provider who willfully refuses to provide medical records or to discuss the medical condition of the injured employee, after a reasonable request is made for such information pursuant to this subsection, shall be subject by the department agency to one or more of the penalties set forth in paragraph (8)(b). The department may adopt rules to carry out this subsection.

(5) INDEPENDENT MEDICAL EXAMINATIONS.—

(a) In any dispute concerning overutilization, medical benefits, compensability, or disability under this chapter, the carrier or the employee may select an independent medical examiner. If the parties agree, the examiner may be a health care provider treating or providing other care to the employee. An independent medical examiner may not render an opinion outside his or her area of expertise, as demonstrated by licensure and applicable practice parameters. The employer and employee shall be entitled to only one independent medical examination per accident and not one independent medical examination per medical specialty. The party requesting and selecting the independent medical examination shall be responsible for all expenses associated with said examination, including, but not limited to, medically necessary diagnostic testing performed and physician or medical care provider fees for the evaluation. The party selecting the independent medical examination shall identify the choice of the independent medical examiner to all other parties within 15 days after the date the independent medical examination is to take place. Failure to timely provide such notification shall preclude the requesting party from submitting the findings of such independent medical examiner in a proceeding before a judge of compensation claims. The independent medical examiner may not provide followup care if such recommendation for care is found to be medically necessary. If the employee prevails in a medical dispute as determined in an order by a

judge of compensation claims or if benefits are paid or treatment provided after the employee has obtained an independent medical examination based upon the examiner's findings, the costs of such examination shall be paid by the employer or carrier.

(b) Each party is bound by his or her selection of an independent medical examiner, including the selection of the independent medical examiner in accordance with s. 440.134 and the opinions of such independent medical examiner. Each party ~~and~~ is entitled to an alternate examiner only if:

1. The examiner is not qualified to render an opinion upon an aspect of the employee's illness or injury which is material to the claim or petition for benefits;

2. The examiner ceases to practice in the specialty relevant to the employee's condition;

3. The examiner is unavailable due to injury, death, or relocation outside a reasonably accessible geographic area; or

4. The parties agree to an alternate examiner.

~~Any party may request, or a judge of compensation claims may require, designation of an agency medical advisor as an independent medical examiner. The opinion of the advisors acting as examiners shall not be afforded the presumption set forth in paragraph (9)(c).~~

(c) The carrier may, at its election, contact the claimant directly to schedule a reasonable time for an independent medical examination. The carrier must confirm the scheduling agreement in writing with the claimant and the within 5 days and notify claimant's counsel, if any, at least 7 days before the date upon which the independent medical examination is scheduled to occur. An attorney representing a claimant is not authorized to schedule the self-insured employer's or carrier's independent medical evaluations under this subsection. Neither the self-insured employer nor the carrier shall be responsible for scheduling any independent medical examination other than an employer or carrier independent medical examination.

(d) If the employee fails to appear for the independent medical examination scheduled by the employer or carrier without good cause and fails to advise the physician at least 24 hours before the scheduled date for the examination that he or she cannot appear, the employee is barred from recovering compensation for any period during which he or she has refused to submit to such examination. Further, the employee shall reimburse the employer or carrier 50 percent of the physician's cancellation or no-show fee unless the employer or carrier that schedules the examination fails to timely provide to the employee a written confirmation of the date of the examination pursuant to paragraph (c) which includes an explanation of why he or she failed to appear. The employee may appeal to a judge of compensation claims for reimbursement when the employer or carrier withholds payment in excess of the authority granted by this section.

(e) No medical opinion other than the opinion of a medical advisor appointed by the judge of compensation claims or ~~the department agency~~, an independent medical examiner, or an authorized treating provider is admissible in proceedings before the judges of compensation claims.

(f) Attorney's fees incurred by an injured employee in connection with delay of or opposition to an independent medical examination, including, but not limited to, motions for protective orders, are not recoverable under this chapter.

(g) When a medical dispute arises, the parties may mutually agree to refer the employee to a licensed physician specializing in the diagnosis and treatment of the medical condition at issue for an independent medical examination and report. Such medical examination shall be referred to as a "consensus independent medical examination." The findings and conclusions of such mutually agreed upon consensus independent medical examination shall be binding on the parties and shall constitute resolution of the medical dispute addressed in the independent consensus medical examination and in any proceeding. Agreement by the parties to a consensus independent medical examination shall not affect the employer's, carrier's, or employee's entitlement to one independent medical examination per accident as provided for in this subsection.

(6) UTILIZATION REVIEW.—Carriers shall review all bills, invoices, and other claims for payment submitted by health care providers in order to identify overutilization and billing errors, including compliance with practice parameters and protocols of treatment established in accordance with this chapter, and may hire peer review consultants or conduct independent medical evaluations. Such consultants, including peer review organizations, are immune from liability in the execution of their functions under this subsection to the extent provided in s. 766.101. If a carrier finds that overutilization of medical services or a billing error has occurred, or there is a violation of the practice parameters and protocols of treatment established in accordance with this chapter, it must disallow or adjust payment for such services or error without order of a judge of compensation claims or the agency, if the carrier, in making its determination, has complied with this section and rules adopted by the agency.

(7) UTILIZATION AND REIMBURSEMENT DISPUTES.—

(a) Any health care provider, carrier, or employer who elects to contest the disallowance or adjustment of payment by a carrier under subsection (6) must, within 30 days after receipt of notice of disallowance or adjustment of payment, petition the agency to resolve the dispute. The petitioner must serve a copy of the petition on the carrier and on all affected parties by certified mail. The petition must be accompanied by all documents and records that support the allegations contained in the petition. Failure of a petitioner to submit such documentation to the agency results in dismissal of the petition.

(b) The carrier must submit to the agency within 10 days after receipt of the petition all documentation substantiating the carrier's disallowance

or adjustment. Failure of the carrier to timely submit the requested documentation to the agency within 10 days constitutes a waiver of all objections to the petition.

(c) Within 60 days after receipt of all documentation, the agency must provide to the petitioner, the carrier, and the affected parties a written determination of whether the carrier properly adjusted or disallowed payment. The agency must be guided by standards and policies set forth in this chapter, including all applicable reimbursement schedules, practice parameters, and protocols of treatment, in rendering its determination.

(d) If the agency finds an improper disallowance or improper adjustment of payment by an insurer, the insurer shall reimburse the health care provider, facility, insurer, or employer within 30 days, subject to the penalties provided in this subsection.

(e) The agency shall adopt rules to carry out this subsection. The rules may include provisions for consolidating petitions filed by a petitioner and expanding the timetable for rendering a determination upon a consolidated petition.

(f) Any carrier that engages in a pattern or practice of arbitrarily or unreasonably disallowing or reducing payments to health care providers may be subject to one or more of the following penalties imposed by the agency:

1. Repayment of the appropriate amount to the health care provider.
2. An administrative fine assessed by the agency in an amount not to exceed \$5,000 per instance of improperly disallowing or reducing payments.
3. Award of the health care provider's costs, including a reasonable attorney's fee, for prosecuting the petition.

(8) PATTERN OR PRACTICE OF OVERUTILIZATION.—

(a) Carriers must report to the agency all instances of overutilization including, but not limited to, all instances in which the carrier disallows or adjusts payment or a determination has been made that the provided or recommended treatment is in excess of the practice parameters and protocols of treatment established in this chapter. The agency shall determine whether a pattern or practice of overutilization exists.

(b) If the agency determines that a health care provider has engaged in a pattern or practice of overutilization or a violation of this chapter or rules adopted by the agency, including a pattern or practice of providing treatment in excess of the practice parameters or protocols of treatment, it may impose one or more of the following penalties:

1. An order of the agency barring the provider from payment under this chapter;
2. Deauthorization of care under review;

3. Denial of payment for care rendered in the future;
4. Decertification of a health care provider certified as an expert medical advisor under subsection (9) or of a rehabilitation provider certified under s. 440.49;
5. An administrative fine assessed by the agency in an amount not to exceed \$5,000 per instance of overutilization or violation; and
6. Notification of and review by the appropriate licensing authority pursuant to s. 440.106(3).

(9) EXPERT MEDICAL ADVISORS.—

(a) The agency shall certify expert medical advisors in each specialty to assist the agency and the judges of compensation claims within the advisor's area of expertise as provided in this section. The agency shall, in a manner prescribed by rule, in certifying, recertifying, or decertifying an expert medical advisor, consider the qualifications, training, impartiality, and commitment of the health care provider to the provision of quality medical care at a reasonable cost. As a prerequisite for certification or recertification, the agency shall require, at a minimum, that an expert medical advisor have specialized workers' compensation training or experience under the workers' compensation system of this state and board certification or board eligibility.

(b) The agency shall contract with one or more entities that employ, contract with, or otherwise secure or employ expert medical advisors to provide peer review or expert medical consultation, opinions, and testimony to the agency or to a judge of compensation claims in connection with resolving disputes relating to reimbursement, differing opinions of health care providers, and health care and physician services rendered under this chapter, including utilization issues. The agency shall by rule establish the qualifications of expert medical advisors, including training and experience in the workers' compensation system in the state and the expert medical advisor's knowledge of and commitment to the standards of care, practice parameters, and protocols established pursuant to this chapter. Expert medical advisors contracting with the agency shall, as a term of such contract, agree to provide consultation or services in accordance with the timetables set forth in this chapter and to abide by rules adopted by the agency, including, but not limited to, rules pertaining to procedures for review of the services rendered by health care providers and preparation of reports and testimony or recommendations for submission to the agency or the judge of compensation claims.

(c) If there is disagreement in the opinions of the health care providers, if two health care providers disagree on medical evidence supporting the employee's complaints or the need for additional medical treatment, or if two health care providers disagree that the employee is able to return to work, the agency may, and the judge of compensation claims shall, upon his or her own motion or within 15 days after receipt of a written request by either the injured employee, the employer, or the carrier, order the injured employee to be evaluated by an expert medical advisor. The opinion of the expert

medical advisor is presumed to be correct unless there is clear and convincing evidence to the contrary as determined by the judge of compensation claims. The expert medical advisor appointed to conduct the evaluation shall have free and complete access to the medical records of the employee. An employee who fails to report to and cooperate with such evaluation forfeits entitlement to compensation during the period of failure to report or cooperate.

(d) The expert medical advisor must complete his or her evaluation and issue his or her report to the agency or to the judge of compensation claims within 15 45 days after receipt of all medical records. The expert medical advisor must furnish a copy of the report to the carrier and to the employee.

(e) An expert medical advisor is not liable under any theory of recovery for evaluations performed under this section without a showing of fraud or malice. The protections of s. 766.101 apply to any officer, employee, or agent of the agency and to any officer, employee, or agent of any entity with which the agency has contracted under this subsection.

(f) If the agency or a judge of compensation claims orders ~~determines that~~ the services of a certified expert medical advisor ~~are required~~ to resolve a dispute under this section, the party requesting such examination ~~carrier~~ must compensate the advisor for his or her time in accordance with a schedule adopted by the agency. If the employee prevails in a dispute as determined in an order by a judge of compensation claims based upon the expert medical advisor's findings, the employer or carrier shall pay for the costs of such expert medical advisor. If a judge of compensation claims, upon his or her motion, finds that an expert medical advisor is needed to resolve the dispute, the carrier must compensate the advisor for his or her time in accordance with a schedule adopted by the agency. The agency may assess a penalty not to exceed \$500 against any carrier that fails to timely compensate an advisor in accordance with this section.

(10) WITNESS FEES.—Any health care provider who gives a deposition shall be allowed a witness fee. The amount charged by the witness may not exceed \$200 per hour. An expert witness who has never provided direct professional services to a party but has merely reviewed medical records and provided an expert opinion or has provided only direct professional services that were unrelated to the workers' compensation case may not be allowed a witness fee in excess of \$200 per day.

(11) AUDITS BY AGENCY FOR HEALTH CARE ADMINISTRATION AND THE DEPARTMENT OF INSURANCE; JURISDICTION.—

(a) The Agency for Health Care Administration may investigate health care providers to determine whether providers are complying with this chapter and with rules adopted by the agency, whether the providers are engaging in overutilization, ~~and whether providers are engaging in improper billing practices, and whether providers are adhering to practice parameters and protocols established in accordance with this chapter.~~ If the agency finds that a health care provider has improperly billed, overutilized, or failed to comply with agency rules or the requirements of this chapter, including, but not limited to, practice parameters and protocols established in accordance

with this chapter, it must notify the provider of its findings and may determine that the health care provider may not receive payment from the carrier or may impose penalties as set forth in subsection (8) or other sections of this chapter. If the health care provider has received payment from a carrier for services that were improperly billed, that constitute overutilization, or that were outside practice parameters or protocols established in accordance with this chapter ~~or for overutilization~~, it must return those payments to the carrier. The agency may assess a penalty not to exceed \$500 for each overpayment that is not refunded within 30 days after notification of overpayment by the agency or carrier.

(b) The department shall monitor and audit carriers as provided in s. 624.3161, to determine if medical bills are paid in accordance with this section and department rules. Any employer, if self-insured, or carrier found by the division not to be within 90 percent compliance as to the payment of medical bills after July 1, 1994, must be assessed a fine not to exceed 1 percent of the prior year's assessment levied against such entity under s. 440.51 for every quarter in which the entity fails to attain 90-percent compliance. The department shall fine or otherwise discipline an employer or carrier, pursuant to this chapter, the insurance code, or rules adopted by the department, for each late payment of compensation that is below the minimum 95-percent ~~90-percent~~ performance standard. Any carrier that is found to be not in compliance in subsequent consecutive quarters must implement a medical-bill review program approved by the division, and the carrier is subject to disciplinary action by the Department of Insurance.

(c) The agency has exclusive jurisdiction to decide any matters concerning reimbursement, to resolve any overutilization dispute under subsection (7), and to decide any question concerning overutilization under subsection (8), which question or dispute arises after January 1, 1994.

(d) The following agency actions do not constitute agency action subject to review under ss. 120.569 and 120.57 and do not constitute actions subject to s. 120.56: referral by the entity responsible for utilization review; a decision by the agency to refer a matter to a peer review committee; establishment by a health care provider or entity of procedures by which a peer review committee reviews the rendering of health care services; and the review proceedings, report, and recommendation of the peer review committee.

(12) CREATION OF THREE-MEMBER PANEL; GUIDES OF MAXIMUM REIMBURSEMENT ALLOWANCES.—

(a) A three-member panel is created, consisting of the Insurance Commissioner, or the Insurance Commissioner's designee, and two members to be appointed by the Governor, subject to confirmation by the Senate, one member who, on account of present or previous vocation, employment, or affiliation, shall be classified as a representative of employers, the other member who, on account of previous vocation, employment, or affiliation, shall be classified as a representative of employees. The panel shall determine statewide schedules of maximum reimbursement allowances for medically necessary treatment, care, and attendance provided by physicians,

hospitals, ambulatory surgical centers, work-hardening programs, pain programs, and durable medical equipment. The maximum reimbursement allowances for inpatient hospital care shall be based on a schedule of per diem rates, to be approved by the three-member panel no later than March 1, 1994, to be used in conjunction with a precertification manual as determined by the department, including maximum hours in which an outpatient may remain in observation status, which shall not exceed 23 hours agency. All compensable charges for hospital outpatient care shall be reimbursed at 75 percent of usual and customary charges, except as otherwise provided by this subsection. ~~Until the three-member panel approves a schedule of per diem rates for inpatient hospital care and it becomes effective, all compensable charges for hospital inpatient care must be reimbursed at 75 percent of their usual and customary charges.~~ Annually, the three-member panel shall adopt schedules of maximum reimbursement allowances for physicians, hospital inpatient care, hospital outpatient care, ambulatory surgical centers, work-hardening programs, and pain programs. ~~However, the maximum percentage of increase in the individual reimbursement allowance may not exceed the percentage of increase in the Consumer Price Index for the previous year.~~ An individual physician, hospital, ambulatory surgical center, pain program, or work-hardening program shall be reimbursed either ~~the usual and customary charge for treatment, care, and attendance, the agreed-upon contract price, or the maximum reimbursement allowance in the appropriate schedule, whichever is less.~~

(b) It is the intent of the Legislature to increase the schedule of maximum reimbursement allowances for selected physicians effective January 1, 2004, and to pay for the increases through reductions in payments to hospitals. Revisions developed pursuant to this subsection are limited to the following:

1. Payments for outpatient physical, occupational, and speech therapy provided by hospitals shall be reduced to the schedule of maximum reimbursement allowances for these services which applies to nonhospital providers.

2. Payments for scheduled outpatient nonemergency radiological and clinical laboratory services that are not provided in conjunction with a surgical procedure shall be reduced to the schedule of maximum reimbursement allowances for these services which applies to nonhospital providers.

3. Outpatient reimbursement for scheduled surgeries shall be reduced from 75 percent of charges to 60 percent of charges.

4. Maximum reimbursement for a physician licensed under chapter 458 or chapter 459 shall be increased to 110 percent of the reimbursement allowed by Medicare, using appropriate codes and modifiers or the medical reimbursement level adopted by the three-member panel as of January 1, 2003, whichever is greater.

5. Maximum reimbursement for surgical procedures shall be increased to 140 percent of the reimbursement allowed by Medicare or the medical reimbursement level adopted by the three-member panel as of January 1, 2003, whichever is greater.

(c)(b) As to reimbursement for a prescription medication, the reimbursement amount for a prescription shall be the average wholesale price ~~times~~ 1.2 plus \$4.18 for the dispensing fee, except where the carrier has contracted for a lower amount. Fees for pharmaceuticals and pharmaceutical services shall be reimbursable at the applicable fee schedule amount. Where the employer or carrier has contracted for such services and the employee elects to obtain them through a provider not a party to the contract, the carrier shall reimburse at the schedule, negotiated, or contract price, whichever is lower. No such contract shall rely on a provider that is not reasonably accessible to the employee.

(d)(e) Reimbursement for all fees and other charges for such treatment, care, and attendance, including treatment, care, and attendance provided by any hospital or other health care provider, ambulatory surgical center, work-hardening program, or pain program, must not exceed the amounts provided by the uniform schedule of maximum reimbursement allowances as determined by the panel or as otherwise provided in this section. This subsection also applies to independent medical examinations performed by health care providers under this chapter. ~~Until the three-member panel approves a uniform schedule of maximum reimbursement allowances and it becomes effective, all compensable charges for treatment, care, and attendance provided by physicians, ambulatory surgical centers, work-hardening programs, or pain programs shall be reimbursed at the lowest maximum reimbursement allowance across all 1992 schedules of maximum reimbursement allowances for the services provided regardless of the place of service.~~ In determining the uniform schedule, the panel shall first approve the data which it finds representative of prevailing charges in the state for similar treatment, care, and attendance of injured persons. Each health care provider, health care facility, ambulatory surgical center, work-hardening program, or pain program receiving workers' compensation payments shall maintain records verifying their usual charges. In establishing the uniform schedule of maximum reimbursement allowances, the panel must consider:

1. The levels of reimbursement for similar treatment, care, and attendance made by other health care programs or third-party providers;
2. The impact upon cost to employers for providing a level of reimbursement for treatment, care, and attendance which will ensure the availability of treatment, care, and attendance required by injured workers;
3. The financial impact of the reimbursement allowances upon health care providers and health care facilities, including trauma centers as defined in s. 395.4001, and its effect upon their ability to make available to injured workers such medically necessary remedial treatment, care, and attendance. The uniform schedule of maximum reimbursement allowances must be reasonable, must promote health care cost containment and efficiency with respect to the workers' compensation health care delivery system, and must be sufficient to ensure availability of such medically necessary remedial treatment, care, and attendance to injured workers; and
4. The most recent average maximum allowable rate of increase for hospitals determined by the Health Care Board under chapter 408.

(e)(d) In addition to establishing the uniform schedule of maximum reimbursement allowances, the panel shall:

1. Take testimony, receive records, and collect data to evaluate the adequacy of the workers' compensation fee schedule, nationally recognized fee schedules and alternative methods of reimbursement to certified health care providers and health care facilities for inpatient and outpatient treatment and care.

2. Survey certified health care providers and health care facilities to determine the availability and accessibility of workers' compensation health care delivery systems for injured workers.

3. Survey carriers to determine the estimated impact on carrier costs and workers' compensation premium rates by implementing changes to the carrier reimbursement schedule or implementing alternative reimbursement methods.

4. Submit recommendations on or before January 1, 2003, and biennially thereafter, to the President of the Senate and the Speaker of the House of Representatives on methods to improve the workers' compensation health care delivery system.

The division shall provide data to the panel, including but not limited to, utilization trends in the workers' compensation health care delivery system. The division shall provide the panel with an annual report regarding the resolution of medical reimbursement disputes and any actions pursuant to s. 440.13(8). The division shall provide administrative support and service to the panel to the extent requested by the panel.

(13) REMOVAL OF PHYSICIANS FROM LISTS OF THOSE AUTHORIZED TO RENDER MEDICAL CARE.—The agency shall remove from the list of physicians or facilities authorized to provide remedial treatment, care, and attendance under this chapter the name of any physician or facility found after reasonable investigation to have:

(a) Engaged in professional or other misconduct or incompetency in connection with medical services rendered under this chapter;

(b) Exceeded the limits of his or her or its professional competence in rendering medical care under this chapter, or to have made materially false statements regarding his or her or its qualifications in his or her application;

(c) Failed to transmit copies of medical reports to the employer or carrier, or failed to submit full and truthful medical reports of all his or her or its findings to the employer or carrier as required under this chapter;

(d) Solicited, or employed another to solicit for himself or herself or itself or for another, professional treatment, examination, or care of an injured employee in connection with any claim under this chapter;

(e) Refused to appear before, or to answer upon request of, the agency or any duly authorized officer of the state, any legal question, or to produce any

relevant book or paper concerning his or her conduct under any authorization granted to him or her under this chapter;

(f) Self-referred in violation of this chapter or other laws of this state; or

(g) Engaged in a pattern of practice of overutilization or a violation of this chapter or rules adopted by the agency, including failure to adhere to practice parameters and protocols established in accordance with this chapter.

(14) PAYMENT OF MEDICAL FEES.—

(a) Except for emergency care treatment, fees for medical services are payable only to a health care provider certified and authorized to render remedial treatment, care, or attendance under this chapter. Carriers shall pay, disallow, or deny payment to health care providers in the manner and at times set forth in this chapter. A health care provider may not collect or receive a fee from an injured employee within this state, except as otherwise provided by this chapter. Such providers have recourse against the employer or carrier for payment for services rendered in accordance with this chapter. Payment to health care providers or physicians shall be subject to the medical fee schedule and applicable practice parameters and protocols, regardless of whether the health care provider or claimant is asserting that the payment should be made.

(b) Fees charged for remedial treatment, care, and attendance, except for independent medical examinations and consensus independent medical examinations, may not exceed the applicable fee schedules adopted under this chapter and department rule. Notwithstanding any other provision in this chapter, if a physician or health care provider specifically agrees in writing to follow identified procedures aimed at providing quality medical care to injured workers at reasonable costs, deviations from established fee schedules shall be permitted. Written agreements warranting deviations may include, but are not limited to, the timely scheduling of appointments for injured workers, participating in return-to-work programs with injured workers' employers, expediting the reporting of treatments provided to injured workers, and agreeing to continuing education, utilization review, quality assurance, precertification, and case management systems that are designed to provide needed treatment for injured workers.

(c) Notwithstanding any other provision of this chapter, following overall maximum medical improvement from an injury compensable under this chapter, the employee is obligated to pay a copayment of \$10 per visit for medical services. The copayment shall not apply to emergency care provided to the employee.

(15) PRACTICE PARAMETERS.—The practice parameters and protocols mandated under this chapter shall be the practice parameters and protocols adopted by the United States Agency for Healthcare Research and Quality in effect on January 1, 2003.

~~(a) The Agency for Health Care Administration, in conjunction with the department and appropriate health professional associations and health-related organizations shall develop and may adopt by rule scientifically~~

~~sound practice parameters for medical procedures relevant to workers' compensation claimants. Practice parameters developed under this section must focus on identifying effective remedial treatments and promoting the appropriate utilization of health care resources. Priority must be given to those procedures that involve the greatest utilization of resources either because they are the most costly or because they are the most frequently performed. Practice parameters for treatment of the 10 top procedures associated with workers' compensation injuries including the remedial treatment of lower-back injuries must be developed by December 31, 1994.~~

~~(b) The guidelines may be initially based on guidelines prepared by nationally recognized health care institutions and professional organizations but should be tailored to meet the workers' compensation goal of returning employees to full employment as quickly as medically possible, taking into consideration outcomes data collected from managed care providers and any other inpatient and outpatient facilities serving workers' compensation claimants.~~

~~(c) Procedures must be instituted which provide for the periodic review and revision of practice parameters based on the latest outcomes data, research findings, technological advancements, and clinical experiences, at least once every 3 years.~~

~~(d) Practice parameters developed under this section must be used by carriers and the agency in evaluating the appropriateness and overutilization of medical services provided to injured employees.~~

(16) STANDARDS OF CARE.—The following standards of care shall be followed in providing medical care under this chapter:

(a) Abnormal anatomical findings alone, in the absence of objective relevant medical findings, shall not be an indicator of injury or illness, a justification for the provision of remedial medical care or the assignment of restrictions, or a foundation for limitations.

(b) At all times during evaluation and treatment, the provider shall act on the premise that returning to work is an integral part of the treatment plan. The goal of removing all restrictions and limitations as early as appropriate shall be part of the treatment plan on a continuous basis. The assignment of restrictions and limitations shall be reviewed with each patient exam and upon receipt of new information, such as progress reports from physical therapists and other providers. Consideration shall be given to upgrading or removing the restrictions and limitations with each patient exam, based upon the presence or absence of objective relevant medical findings.

(c) Reasonable necessary medical care of injured employees shall in all situations:

1. Utilize a high intensity, short duration treatment approach that focuses on early activation and restoration of function whenever possible.

2. Include reassessment of the treatment plans, regimes, therapies, prescriptions, and functional limitations or restrictions prescribed by the provider every 30 days.

3. Be focused on treatment of the individual employee's specific clinical dysfunction or status and shall not be based upon nondescript diagnostic labels.

All treatment shall be inherently scientifically logical and the evaluation or treatment procedure must match the documented physiologic and clinical problem. Treatment shall match the type, intensity, and duration of service required by the problem identified.

(17) Failure to comply with this section shall be considered a violation of this chapter and is subject to penalties as provided for in s. 440.525.

Section 16. Paragraphs (d) and (i) of subsection (1) and subsections (2), (6), (7), (8), (9), (10), (11), (17), and (25) of section 440.134, Florida Statutes, are amended to read:

440.134 Workers' compensation managed care arrangement.—

(1) As used in this section, the term:

(d) "Grievance" means a written complaint, other than a petition for benefits, filed by the injured worker pursuant to the requirements of the managed care arrangement, expressing dissatisfaction with the medical care provided by an insurer's workers' compensation managed care arrangement's refusal to provide medical care or the medical care provided arrangement health care providers, expressed in writing by an injured worker.

(i) "Medical care coordinator" means a primary care provider within a provider network who is responsible for managing the medical care of an injured worker including determining other health care providers and health care facilities to which the injured employee will be referred for evaluation or treatment. A medical care coordinator shall be a physician licensed under chapter 458, ~~or~~ an osteopathic physician licensed under chapter 459, a chiropractic physician licensed under chapter 460, or a podiatric physician licensed under chapter 461.

(2)(a) The self-insured employer or carrier may, subject to the terms and limitations specified elsewhere in this section and chapter, furnish to the employee solely through managed care arrangements such medically necessary remedial treatment, care, and attendance for such period as the nature of the injury or the process of recovery requires and which shall be in accordance with practice parameters and protocols established pursuant to this chapter. For any self-insured employer or carrier who elects to deliver the medical benefits required by this chapter through a method other than a workers' compensation managed care arrangement, the discontinuance of the use of the workers' compensation managed care arrangement shall be without regard to the date of the accident, notwithstanding any other provision of law or rule.

(b) The agency shall authorize an insurer to offer or utilize a workers' compensation managed care arrangement after the insurer files a completed application along with the payment of a \$1,000 application fee, and upon the agency's being satisfied that the applicant has the ability to provide quality of care consistent with the prevailing professional standards of care and the insurer and its workers' compensation managed care arrangement otherwise meets the requirements of this section. No insurer may offer or utilize a managed care arrangement without such authorization. The authorization, unless sooner suspended or revoked, shall automatically expire 2 years after the date of issuance unless renewed by the insurer. The authorization shall be renewed upon application for renewal and payment of a renewal fee of \$1,000, provided that the insurer is in compliance with the requirements of this section and any rules adopted hereunder. An application for renewal of the authorization shall be made 90 days prior to expiration of the authorization, on forms provided by the agency. The renewal application shall not require the resubmission of any documents previously filed with the agency if such documents have remained valid and unchanged since their original filing.

(6) The proposed managed care plan of operation must include:

(a) A statement or map providing a clear description of the service area.

(b) A description of the grievance procedure to be used.

(c) A description of the quality assurance program which assures that the health care services provided to workers shall be rendered under reasonable standards of quality of care consistent with the prevailing standards of medical practice in the medical community. The program shall include, but not be limited to:

1. A written statement of goals and objectives that stresses health and return-to-work outcomes as the principal criteria for the evaluation of the quality of care rendered to injured workers.

2. A written statement describing how methodology has been incorporated into an ongoing system for monitoring of care that is individual case oriented and, when implemented, can provide interpretation and analysis of patterns of care rendered to individual patients by individual providers.

3. Written procedures for taking appropriate remedial action whenever, as determined under the quality assurance program, inappropriate or substandard services have been provided or services that should have been furnished have not been provided.

4. A written plan, which includes ongoing review, for providing review of physicians and other licensed medical providers.

5. Appropriate financial incentives to reduce service costs and utilization without sacrificing the quality of service.

6. Adequate methods of peer review and utilization review. The utilization review process shall include a health care ~~facility's facilities~~ precertification mechanism, including, but not limited to, all elective admissions and

nonemergency surgeries and adherence to practice parameters and protocols established in accordance with this chapter.

7. Provisions for resolution of disputes arising between a health care provider and an insurer regarding reimbursements and utilization review.

8. Availability of a process for aggressive medical care coordination, as well as a program involving cooperative efforts by the workers, the employer, and the workers' compensation managed care arrangement to promote early return to work for injured workers.

9. A written plan allowing for the independent medical examination provided for in s. 440.13(5). Notwithstanding any provision to the contrary, the costs for the independent medical examination shall be paid by the carrier if such examination is performed by a physician in the provider network. Otherwise, such costs shall be paid in accordance with s. 440.13(5). An independent medical examination requested by a claimant and paid for by the carrier shall constitute the claimant's one independent medical examination per accident under s. 440.13(5). A process allowing employees to obtain one second medical opinion in the same specialty and within the provider network during the course of treatment for a work-related injury.

10. A provision for the selection of a primary care provider by the employee from among primary providers in the provider network.

11. The written information proposed to be used by the insurer to comply with subparagraph 8.

(7) Written procedures to provide the insurer with timely medical records and information including, but not limited to, work status, work restrictions, date of maximum medical improvement, permanent impairment ratings, and other information as required, including information demonstrating compliance with the practice parameters and protocols of treatment established pursuant to this chapter.

(8) Evidence that appropriate health care providers and administrative staff of the insurer's workers' compensation managed care arrangement have received training and education on the provisions of this chapter; and the administrative rules that govern the provision of remedial treatment, care, and attendance of injured workers; and the practice parameters and protocols of treatment established pursuant to this chapter.

(9) Written procedures and methods to prevent inappropriate or excessive treatment that are in accordance with the practice parameters and protocols of treatment established pursuant to this chapter.

(10) Written procedures and methods for the management of an injured worker's medical care by a medical care coordinator including:

(a) The mechanism for assuring that covered employees receive all initial covered services from a primary care provider participating in the provider network, except for emergency care.

(b) The mechanism for assuring that all continuing covered services be received from the same primary care provider participating in the provider network that provided the initial covered services, except when services from another provider are authorized by the medical care coordinator pursuant to paragraph (d).

(c) The policies and procedures for allowing an employee one change to another provider within the ~~same specialty and provider network as the authorized treating physician during the course of treatment for a work-related injury, in accordance with the procedures provided in s. 440.13(2)(f), if a request is made to the medical care coordinator by the employee; and requiring that special provision be made for more than one such referral through the arrangement's grievance procedures.~~

(d) The process for assuring that all referrals authorized by a medical care coordinator, in accordance with the practice parameters and protocols of treatment established pursuant to this chapter, are made to the participating network providers, unless medically necessary treatment, care, and attendance are not available and accessible to the injured worker in the provider network.

(e) Assignment of a medical care coordinator licensed under chapter 458 or chapter 459 to manage care by physicians licensed under chapter 458 or chapter 459, a medical care coordinator licensed under chapter 460 to manage care by physicians licensed under chapter 460, and a medical care coordinator licensed under chapter 461 to manage care by physicians licensed under chapter 461 upon request by an injured employee for care by a physician licensed under chapter 458, chapter 459, chapter 460, or chapter 461.

(11) A description of the use of workers' compensation practice parameters and protocols of treatment for health care services ~~when adopted by the agency.~~

(17) Notwithstanding any other provisions of this chapter, when a carrier provides medical care through a workers' compensation managed care arrangement, pursuant to this section, those workers who are subject to the arrangement must receive medical services for work-related injuries and diseases as prescribed in the contract, provided the employer and carrier have provided notice to the employees of the arrangement in a manner approved by the agency and the medical services are in accordance with the practice parameters and protocols established pursuant to this chapter. Treatment received outside the workers' compensation managed care arrangement is not compensable, regardless of the purpose of the treatment, including, but not limited to, evaluations, examinations, or diagnostic studies to determine causation between medical findings and a compensable accident, the existence or extent of impairments or disabilities, and whether the injured employee has reached maximum medical improvement, unless authorized by the carrier prior to the treatment date.

(25) The agency shall adopt rules that specify:

(a) Procedures for authorization and examination of workers' compensation managed care arrangements by the agency.

(b) Requirements and procedures for authorization of workers' compensation arrangement provider networks and procedures for the agency to grant exceptions from accessibility of services.

(c) Requirements and procedures for case management, utilization management, and peer review.

(d) Requirements and procedures for quality assurance and medical records.

(e) Requirements and procedures for dispute resolution in conformance with this chapter.

(f) Requirements and procedures for employee and provider education.

(g) Requirements and procedures for reporting data regarding grievances, return-to-work outcomes, and provider networks.

Section 17. Subsections (1) and (4) and paragraph (b) of subsection (5) of section 440.14, Florida Statutes, are amended to read:

440.14 Determination of pay.—

(1) Except as otherwise provided in this chapter, the average weekly wages of the injured employee on the date of the accident at the time of the injury shall be taken as the basis upon which to compute compensation and shall be determined, subject to the limitations of s. 440.12(2), as follows:

(a) If the injured employee has worked in the employment in which she or he was working on the date of the accident at the time of the injury, whether for the same or another employer, during substantially the whole of 13 weeks immediately preceding the accident injury, her or his average weekly wage shall be one-thirteenth of the total amount of wages earned in such employment during the 13 weeks. As used in this paragraph, the term "substantially the whole of 13 weeks" means the calendar shall be deemed to mean and refer to a constructive period of 13 weeks as a whole, which shall be defined as the 13 calendar weeks before the date of the accident, excluding the week during which the accident occurred, a consecutive period of 91 days, and The term "during substantially the whole of 13 weeks" shall be deemed to mean during not less than ~~75~~ 90 percent of the total customary ~~full-time~~ hours of employment within such period considered as a whole.

(b) If the injured employee has not worked in such employment during substantially the whole of 13 weeks immediately preceding the accident injury, the wages of a similar employee in the same employment who has worked substantially the whole of such 13 weeks shall be used in making the determination under the preceding paragraph.

(c) If an employee is a seasonal worker and the foregoing method cannot be fairly applied in determining the average weekly wage, then the employee may use, instead of the 13 weeks immediately preceding the accident injury,

the calendar year or the 52 weeks immediately preceding the accident injury. The employee will have the burden of proving that this method will be more reasonable and fairer than the method set forth in paragraphs (a) and (b) and, further, must document prior earnings with W-2 forms, written wage statements, or income tax returns. The employer shall have 30 days following the receipt of this written proof to adjust the compensation rate, including the making of any additional payment due for prior weekly payments, based on the lower rate compensation.

(d) If any of the foregoing methods cannot reasonably and fairly be applied, the full-time weekly wages of the injured employee shall be used, except as otherwise provided in paragraph (e) or paragraph (f).

(e) If it is established that the injured employee was under 22 years of age when the accident occurred ~~injured~~ and that under normal conditions her or his wages should be expected to increase during the period of disability, the fact may be considered in arriving at her or his average weekly wages.

(f) If it is established that the injured employee was a part-time worker on the date of the accident ~~at the time of the injury~~, that she or he had adopted part-time employment as a customary practice, and that under normal working conditions she or he probably would have remained a part-time worker during the period of disability, these factors shall be considered in arriving at her or his average weekly wages. For the purpose of this paragraph, the term "part-time worker" means an individual who customarily works less than the full-time hours or full-time workweek of a similar employee in the same employment.

(g) If compensation is due for a fractional part of the week, the compensation for such fractional part shall be determined by dividing the weekly compensation rate by the number of days employed per week to compute the amount due for each day.

(4) Upon termination of the employee (or upon termination of the payment of fringe benefits of any employee who is collecting indemnity benefits pursuant to s. 440.15(2) or (3)~~(b)~~), the employer shall within 7 days of such termination file a corrected 13-week wage statement reflecting the wages paid and the fringe benefits that had been paid to the injured employee, as provided in s. 440.02(27).

(5)

(b) The employee waives any entitlement to interest, penalties, and attorney's fees during the period in which the employee has not provided information concerning the loss of earnings from concurrent employment. Carriers are not subject to penalties by the division under s. 440.20(8)(b) ~~and~~ (e) for unpaid compensation related to concurrent employment during the period in which the employee has not provided information concerning the loss of earnings from concurrent employment.

Section 18. Section 440.15, Florida Statutes, is amended to read:

440.15 Compensation for disability.—Compensation for disability shall be paid to the employee, subject to the limits provided in s. 440.12(2), as follows:

(1) PERMANENT TOTAL DISABILITY.—

(a) In case of total disability adjudged to be permanent, 66 $\frac{2}{3}$ percent of the average weekly wages shall be paid to the employee during the continuance of such total disability. No compensation shall be payable under this section if the employee is engaged in, or is physically capable of engaging in, at least sedentary employment.

(b) In the following cases, an injured employee is presumed to be permanently and totally disabled unless the employer or carrier establishes that the employee is physically capable of engaging in at least sedentary employment within a 50-mile radius of the employee's residence:

1. Spinal cord injury involving severe paralysis of an arm, a leg, or the trunk;

2. Amputation of an arm, a hand, a foot, or a leg involving the effective loss of use of that appendage;

3. Severe brain or closed-head injury as evidenced by:

a. Severe sensory or motor disturbances;

b. Severe communication disturbances;

c. Severe complex integrated disturbances of cerebral function;

d. Severe episodic neurological disorders; or

e. Other severe brain and closed-head injury conditions at least as severe in nature as any condition provided in sub-subparagraphs a.-d.;

4. Second-degree or third-degree burns of 25 percent or more of the total body surface or third-degree burns of 5 percent or more to the face and hands; or

5. Total or industrial blindness.

In all other cases, in order to obtain permanent total disability benefits, the employee must establish that he or she is not able to engage in at least sedentary employment, within a 50-mile radius of the employee's residence, due to his or her physical limitation. Entitlement to such benefits shall cease when the employee reaches age 75, unless the employee is not eligible for social security benefits under 42 U.S.C. s. 402 or s. 423 because the employee's compensable injury has prevented the employee from working sufficient quarters to be eligible for such benefits, notwithstanding any age limits. If the accident occurred on or after the employee reaches age 70, benefits shall be payable during the continuance of permanent total disability, not to exceed 5 years following the determination of permanent total disability. Only a catastrophic injury as defined in s. 440.02 shall, in the absence of

~~conclusive proof of a substantial earning capacity, constitute permanent total disability. Only claimants with catastrophic injuries or claimants who are incapable of engaging in employment, as described in this paragraph,~~ are eligible for permanent total benefits. In no other case may permanent total disability be awarded.

(c) In cases of permanent total disability resulting from injuries that occurred prior to July 1, 1955, such payments shall not be made in excess of 700 weeks.

(d) If an employee who is being paid compensation for permanent total disability becomes rehabilitated to the extent that she or he establishes an earning capacity, the employee shall be paid, instead of the compensation provided in paragraph (a), benefits pursuant to subsection (3). The department shall adopt rules to enable a permanently and totally disabled employee who may have reestablished an earning capacity to undertake a trial period of reemployment without prejudicing her or his return to permanent total status in the case that such employee is unable to sustain an earning capacity.

(e)1. ~~The employer's or carrier's right to conduct vocational evaluations or testing by the employer's or carrier's chosen rehabilitation advisor or provider pursuant to s. 440.491 continues even after the employee has been accepted or adjudicated as entitled to compensation under this chapter and costs for such evaluations and testing shall be borne by the employer or carrier, respectively.~~ This right includes, but is not limited to, instances in which such evaluations or tests are recommended by a treating physician or independent medical-examination physician, instances warranted by a change in the employee's medical condition, or instances in which the employee appears to be making appropriate progress in recuperation. This right may not be exercised more than once every calendar year.

2. The carrier must confirm the scheduling of the vocational evaluation or testing in writing, and must notify the employee and the employee's counsel, if any, at least 7 days before the date on which vocational evaluation or testing is scheduled to occur.

~~3. Pursuant to an order of the judge of compensation claims,~~ The employer or carrier may withhold payment of benefits for permanent total disability or supplements for any period during which the employee willfully fails or refuses to appear without good cause for the scheduled vocational evaluation or testing.

(f)1. If permanent total disability results from injuries that occurred subsequent to June 30, 1955, and for which the liability of the employer for compensation has not been discharged under s. 440.20(11), the injured employee shall receive additional weekly compensation benefits equal to 3 ~~5~~ percent of her or his weekly compensation rate, as established pursuant to the law in effect on the date of her or his injury, multiplied by the number of calendar years since the date of injury. The weekly compensation payable and the additional benefits payable under this paragraph, when combined, may not exceed the maximum weekly compensation rate in effect at the time of payment as determined pursuant to s. 440.12(2). ~~Entitlement to~~ These

supplemental payments shall ~~not be paid or payable after the employee attains~~ ~~cease at age 62, regardless of whether~~ if the employee has applied for or is eligible to apply ~~is eligible~~ for social security benefits under 42 U.S.C. s. ss. 402 or s. and 423, unless the employee is not eligible for social security benefits under 42 U.S.C. s. 402 or s. 423 because the employee's compensable injury has prevented the employee from working sufficient quarters to be eligible for such benefits whether or not the employee has applied for such benefits. These supplemental benefits shall be paid by the department out of the Workers' Compensation Administration Trust Fund when the injury occurred subsequent to June 30, 1955, and before July 1, 1984. These supplemental benefits shall be paid by the employer when the injury occurred on or after July 1, 1984. Supplemental benefits are not payable for any period prior to October 1, 1974.

2.a. The department shall provide by rule for the periodic reporting to the department of all earnings of any nature and social security income by the injured employee entitled to or claiming additional compensation under subparagraph 1. Neither the department nor the employer or carrier shall make any payment of those additional benefits provided by subparagraph 1. for any period during which the employee willfully fails or refuses to report upon request by the department in the manner prescribed by such rules.

b. The department shall provide by rule for the periodic reporting to the employer or carrier of all earnings of any nature and social security income by the injured employee entitled to or claiming benefits for permanent total disability. The employer or carrier is not required to make any payment of benefits for permanent total disability for any period during which the employee willfully fails or refuses to report upon request by the employer or carrier in the manner prescribed by such rules or if any employee who is receiving permanent total disability benefits refuses to apply for or cooperate with the employer or carrier in applying for social security benefits.

3. When an injured employee receives a full or partial lump-sum advance of the employee's permanent total disability compensation benefits, the employee's benefits under this paragraph shall be computed on the employee's weekly compensation rate as reduced by the lump-sum advance.

(2) TEMPORARY TOTAL DISABILITY.—

(a) Subject to subsection (7), in case of disability total in character but temporary in quality, $66\frac{2}{3}$ percent of the average weekly wages shall be paid to the employee during the continuance thereof, not to exceed 104 weeks except as provided in this subsection, s. 440.12(1), and s. 440.14(3). Once the employee reaches the maximum number of weeks allowed, or the employee reaches the date of maximum medical improvement, whichever occurs earlier, temporary disability benefits shall cease and the injured worker's permanent impairment shall be determined.

(b) Notwithstanding the provisions of paragraph (a), an employee who has sustained the loss of an arm, leg, hand, or foot, has been rendered a paraplegic, paraparetic, quadriplegic, or quadriparetic, or has lost the sight of both eyes shall be paid temporary total disability of 80 percent of her or

his average weekly wage. The increased temporary total disability compensation provided for in this paragraph must not extend beyond 6 months from the date of the accident; however, such benefits shall not be due or payable if the employee is eligible for, entitled to, or collecting permanent total disability benefits. The compensation provided by this paragraph is not subject to the limits provided in s. 440.12(2), but instead is subject to a maximum weekly compensation rate of \$700. If, at the conclusion of this period of increased temporary total disability compensation, the employee is still temporarily totally disabled, the employee shall continue to receive temporary total disability compensation as set forth in paragraphs (a) and (c). The period of time the employee has received this increased compensation will be counted as part of, and not in addition to, the maximum periods of time for which the employee is entitled to compensation under paragraph (a) but not paragraph (c).

(c) Temporary total disability benefits paid pursuant to this subsection shall include such period as may be reasonably necessary for training in the use of artificial members and appliances, and shall include such period as the employee may be receiving training and education under a program pursuant to s. 440.491. ~~Notwithstanding s. 440.02, the date of maximum medical improvement for purposes of paragraph (3)(b) shall be no earlier than the last day for which such temporary disability benefits are paid.~~

(d) The department shall, by rule, provide for the periodic reporting to the department, employer, or carrier of all earned income, including income from social security, by the injured employee who is entitled to or claiming benefits for temporary total disability. The employer or carrier is not required to make any payment of benefits for temporary total disability for any period during which the employee willfully fails or refuses to report upon request by the employer or carrier in the manner prescribed by the rules. The rule must require the claimant to personally sign the claim form and attest that she or he has reviewed, understands, and acknowledges the foregoing.

(3) PERMANENT IMPAIRMENT AND ~~WAGE LOSS~~ BENEFITS.—

(a) ~~Impairment benefits.~~—

1. Once the employee has reached the date of maximum medical improvement, impairment benefits are due and payable within 14 ~~20~~ days after the carrier has knowledge of the impairment.

~~2.~~ The three-member panel, in cooperation with the department, shall establish and use a uniform permanent impairment rating schedule. This schedule must be based on medically or scientifically demonstrable findings as well as the systems and criteria set forth in the American Medical Association's Guides to the Evaluation of Permanent Impairment; the Snellen Charts, published by American Medical Association Committee for Eye Injuries; and the Minnesota Department of Labor and Industry Disability Schedules. The schedule must ~~should~~ be based upon objective findings. The schedule shall be more comprehensive than the AMA Guides to the Evaluation of Permanent Impairment and shall expand the areas already addressed and address additional areas not currently contained in the guides.

On August 1, 1979, and pending the adoption, by rule, of a permanent schedule, Guides to the Evaluation of Permanent Impairment, copyright 1977, 1971, 1988, by the American Medical Association, shall be the temporary schedule and shall be used for the purposes hereof. For injuries after July 1, 1990, pending the adoption by rule of a uniform disability rating agency schedule, the Minnesota Department of Labor and Industry Disability Schedule shall be used unless that schedule does not address an injury. In such case, the Guides to the Evaluation of Permanent Impairment by the American Medical Association shall be used. Determination of permanent impairment under this schedule must be made by a physician licensed under chapter 458, a doctor of osteopathic medicine licensed under chapters 458 and 459, a chiropractic physician licensed under chapter 460, a podiatric physician licensed under chapter 461, an optometrist licensed under chapter 463, or a dentist licensed under chapter 466, as appropriate considering the nature of the injury. No other persons are authorized to render opinions regarding the existence of or the extent of permanent impairment.

~~(c)3.~~ All impairment income benefits shall be based on an impairment rating using the impairment schedule referred to in paragraph (b) subparagraph 2. Impairment income benefits are paid ~~biweekly~~ weekly at the rate of ~~75~~ 50 percent of the employee's average weekly temporary total disability benefit not to exceed the maximum weekly benefit under s. 440.12; provided, however, that such benefits shall be reduced by 50 percent for each week in which the employee has earned income equal to or in excess of the employee's average weekly wage. An employee's entitlement to impairment income benefits begins the day after the employee reaches maximum medical improvement or the expiration of temporary benefits, whichever occurs earlier, and continues until the earlier of:

1.a. The expiration of a period computed at the rate of 3 weeks for each percentage point of impairment; or

2.b. The death of the employee.

Impairment income benefits as defined by this subsection are payable only for impairment ratings for physical impairments. If objective medical findings can substantiate a permanent psychiatric impairment resulting from the accident, permanent impairment benefits are limited for the permanent psychiatric impairment to 1-percent permanent impairment.

~~(d)4.~~ After the employee has been certified by a doctor as having reached maximum medical improvement or 6 weeks before the expiration of temporary benefits, whichever occurs earlier, the certifying doctor shall evaluate the condition of the employee and assign an impairment rating, using the impairment schedule referred to in paragraph (b) subparagraph 2. ~~Compensation is not payable for the mental, psychological, or emotional injury arising out of depression from being out of work.~~ If the certification and evaluation are performed by a doctor other than the employee's treating doctor, the certification and evaluation must be submitted to the treating doctor, the employee, and the carrier within 10 days after the evaluation. ~~and~~ The treating doctor must indicate to the carrier agreement or disagreement with the other doctor's certification and evaluation.

1. The certifying doctor shall issue a written report to the department, the employee, and the carrier certifying that maximum medical improvement has been reached, stating the impairment rating to the body as a whole, and providing any other information required by the department by rule. The carrier shall establish an overall maximum medical improvement date and permanent impairment rating, based upon all such reports.

2. Within 14 days after the carrier's knowledge of each maximum medical improvement date and impairment rating to the body as a whole upon which the carrier is paying benefits, the carrier shall report such maximum medical improvement date and, when determined, the overall maximum medical improvement date and associated impairment rating to the department in a format as set forth in department rule. If the employee has not been certified as having reached maximum medical improvement before the expiration of 98 102 weeks after the date temporary total disability benefits begin to accrue, the carrier shall notify the treating doctor of the requirements of this section.

(e)5. The carrier shall pay the employee impairment income benefits for a period based on the impairment rating.

(f)6. The department may by rule specify forms and procedures governing the method of payment of wage loss and impairment benefits under this section for dates of accidents before January 1, 1994, and for dates of accidents on or after January 1, 1994.

(b) ~~Supplemental benefits.—~~

1. ~~All supplemental benefits must be paid in accordance with this subsection. An employee is entitled to supplemental benefits as provided in this paragraph as of the expiration of the impairment period, if:~~

a. ~~The employee has an impairment rating from the compensable injury of 20 percent or more as determined pursuant to this chapter;~~

b. ~~The employee has not returned to work or has returned to work earning less than 80 percent of the employee's average weekly wage as a direct result of the employee's impairment; and~~

e. ~~The employee has in good faith attempted to obtain employment commensurate with the employee's ability to work.~~

2. ~~If an employee is not entitled to supplemental benefits at the time of payment of the final weekly impairment income benefit because the employee is earning at least 80 percent of the employee's average weekly wage, the employee may become entitled to supplemental benefits at any time within 1 year after the impairment income benefit period ends if:~~

a. ~~The employee earns wages that are less than 80 percent of the employee's average weekly wage for a period of at least 90 days;~~

b. ~~The employee meets the other requirements of subparagraph 1.; and~~

~~e.—The employee's decrease in earnings is a direct result of the employee's impairment from the compensable injury.~~

~~3.—If an employee earns wages that are at least 80 percent of the employee's average weekly wage for a period of at least 90 days during which the employee is receiving supplemental benefits, the employee ceases to be entitled to supplemental benefits for the filing period. Supplemental benefits that have been terminated shall be reinstated when the employee satisfies the conditions enumerated in subparagraph 2. and files the statement required under subparagraph 4. Notwithstanding any other provision, if an employee is not entitled to supplemental benefits for 12 consecutive months, the employee ceases to be entitled to any additional income benefits for the compensable injury. If the employee is discharged within 12 months after losing entitlement under this subsection, benefits may be reinstated if the employee was discharged at that time with the intent to deprive the employee of supplemental benefits.~~

~~4.—After the initial determination of supplemental benefits, the employee must file a statement with the carrier stating that the employee has earned less than 80 percent of the employee's average weekly wage as a direct result of the employee's impairment, stating the amount of wages the employee earned in the filing period, and stating that the employee has in good faith sought employment commensurate with the employee's ability to work. The statement must be filed quarterly on a form and in the manner prescribed by the department. The department may modify the filing period as appropriate to an individual case. Failure to file a statement relieves the carrier of liability for supplemental benefits for the period during which a statement is not filed.~~

~~5.—The carrier shall begin payment of supplemental benefits not later than the seventh day after the expiration date of the impairment income benefit period and shall continue to timely pay those benefits. The carrier may request a mediation conference for the purpose of contesting the employee's entitlement to or the amount of supplemental income benefits.~~

~~6.—Supplemental benefits are calculated quarterly and paid monthly. For purposes of calculating supplemental benefits, 80 percent of the employee's average weekly wage and the average wages the employee has earned per week are compared quarterly. For purposes of this paragraph, if the employee is offered a bona fide position of employment that the employee is capable of performing, given the physical condition of the employee and the geographic accessibility of the position, the employee's weekly wages are considered equivalent to the weekly wages for the position offered to the employee.~~

~~7.—Supplemental benefits are payable at the rate of 80 percent of the difference between 80 percent of the employee's average weekly wage determined pursuant to s. 440.14 and the weekly wages the employee has earned during the reporting period, not to exceed the maximum weekly income benefit under s. 440.12.~~

~~8.—The department may by rule define terms that are necessary for the administration of this section and forms and procedures governing the~~

method of payment of supplemental benefits for dates of accidents before January 1, 1994, and for dates of accidents on or after January 1, 1994.

~~(c) Duration of temporary impairment and supplemental income benefits.—The employee's eligibility for temporary benefits, impairment income benefits, and supplemental benefits terminates on the expiration of 401 weeks after the date of injury.~~

(g) Notwithstanding paragraph (c), for accidents occurring on or after October 1, 2003, an employee's entitlement to impairment income benefits begins the day after the employee reaches maximum medical improvement or the expiration of temporary benefits, whichever occurs earlier, and continues for the following periods:

1. Two weeks of benefits are to be paid to the employee for each percentage point of impairment from 1 percent up to and including 10 percent.

2. For each percentage point of impairment from 11 percent up to and including 15 percent, 3 weeks of benefits are to be paid.

3. For each percentage point of impairment from 16 percent up to and including 20 percent, 4 weeks of benefits are to be paid.

4. For each percentage point of impairment from 21 percent and higher, 6 weeks of benefits are to be paid.

(4) TEMPORARY PARTIAL DISABILITY.—

(a) Subject to subsection (7), in case of temporary partial disability, compensation shall be equal to 80 percent of the difference between 80 percent of the employee's average weekly wage and the salary, wages, and other remuneration the employee is able to earn post injury, as compared weekly; however, the weekly temporary partial disability benefits may not exceed an amount equal to 66 $\frac{2}{3}$ percent of the employee's average weekly wage at the time of accident injury. In order to simplify the comparison of the preinjury average weekly wage with the salary, wages, and other remuneration the employee is able to earn post injury, the department may by rule provide for payment of the initial installment of temporary partial disability benefits to be paid as a partial week so that payment for remaining weeks of temporary partial disability can the modification of the weekly comparison so as to coincide as closely as possible with the post injury employer's work week injured worker's pay periods. The amount determined to be the salary, wages, and other remuneration the employee is able to earn shall in no case be less than the sum actually being earned by the employee, including earnings from sheltered employment. Benefits shall be payable under this subsection only if overall maximum medical improvement has not been reached and the medical conditions resulting from the accident create restrictions on the injured employee's ability to return to work.

(b) Within 5 business days after the carrier's knowledge of the employee's release to restricted work, the carrier shall mail to the employee and employer an informational letter, adopted by department rule, explaining the employee's possible eligibility and responsibilities for temporary partial disability benefits.

(c) When an employee returns to work with the restrictions resulting from the accident and is earning wages less than 80 percent of the preinjury average weekly wage, the first installment of temporary partial disability benefits is due 7 days after the last date of the post injury employer's first biweekly work week. Thereafter, payment for temporary partial benefits shall be paid biweekly no later than the 7th day following the last day of each biweekly work week.

(d) If the employee is unable to return to work with the restrictions resulting from the accident and is not earning wages, salary, or other remuneration, temporary partial disability benefits shall be paid no later than the last day of each biweekly period. The employee shall notify the carrier within 5 business days after returning to work. Failure to notify the carrier of the establishment of an earning capacity in the required time shall result in a suspension or nonpayment of temporary partial disability benefits until the proper notification is provided.

(e)(b) Such benefits shall be paid during the continuance of such disability, not to exceed a period of 104 weeks, as provided by this subsection and subsection (2). Once the injured employee reaches the maximum number of weeks, temporary disability benefits cease and the injured worker's permanent impairment must be determined. If the employee is terminated from post injury employment based on the employee's misconduct, temporary partial disability benefits are not payable as provided for in this section. The department shall may by rule specify forms and procedures governing the method and time for of payment of temporary disability benefits for dates of accidents before January 1, 1994, and for dates of accidents on or after January 1, 1994.

(5) SUBSEQUENT INJURY.—

(a) The fact that an employee has suffered previous disability, impairment, anomaly, or disease, or received compensation therefor, shall not preclude her or him from benefits, as specified in paragraph (b), for a subsequent aggravation or acceleration of the preexisting condition or not preclude benefits for death resulting therefrom, except that no benefits shall be payable if the employee, at the time of entering into the employment of the employer by whom the benefits would otherwise be payable, falsely represents herself or himself in writing as not having previously been disabled or compensated because of such previous disability, impairment, anomaly, or disease and the employer detrimentally relies on the misrepresentation. Compensation for temporary disability, medical benefits, and wage-loss benefits shall not be subject to apportionment.

(b) If a compensable injury, disability, or need for medical care permanent impairment, or any portion thereof, is a result of aggravation or acceleration of a preexisting condition, or is the result of merger with a preexisting condition, only the disabilities and medical treatment associated with such compensable injury shall be payable under this chapter, excluding the degree of disability or medical conditions existing at the time of the impairment rating or at the time of the accident, regardless of whether the preexisting condition was disabling at the time of the accident or at the time of

~~the impairment rating and without considering whether the preexisting condition would be disabling without the compensable accident impairment, an employee eligible to receive impairment benefits under paragraph (3)(a) shall receive such benefits for the total impairment found to result, excluding the degree of impairment existing at the time of the subject accident or injury or which would have existed by the time of the impairment rating without the intervention of the compensable accident or injury. The degree of permanent impairment or disability attributable to the accident or injury shall be compensated in accordance with this section, apportioning out the preexisting condition based on the anatomical impairment rating attributable to the preexisting condition. Medical benefits shall be paid apportioning out the percentage of the need for such care attributable to the preexisting condition~~ paragraph (3)(a). As used in this paragraph, “merger” means the combining of a preexisting permanent impairment or disability with a subsequent compensable permanent impairment or disability which, when the effects of both are considered together, result in a permanent impairment or disability rating which is greater than the sum of the two permanent impairment or disability ratings when each impairment or disability is considered individually.

(6) ~~OBLIGATION TO REHIRE.~~—If the employer has not in good faith made available to the employee, within a 100-mile radius of the employee’s residence, work appropriate to the employee’s physical limitations within 30 days after the carrier notifies the employer of maximum medical improvement and the employee’s physical limitations, the employer shall pay to the department for deposit into the Workers’ Compensation Administration Trust Fund a fine of \$250 for every \$5,000 of the employer’s workers’ compensation premium or payroll, not to exceed \$2,000 per violation, as the department requires by rule. ~~The employer is not subject to this subsection if the employee is receiving permanent total disability benefits or if the employer has 50 or fewer employees.~~

(6)(7) ~~EMPLOYEE REFUSES EMPLOYMENT.~~—If an injured employee refuses employment suitable to the capacity thereof, offered to or procured therefor, such employee shall not be entitled to any compensation at any time during the continuance of such refusal unless at any time in the opinion of the judge of compensation claims such refusal is justifiable. Time periods for the payment of benefits in accordance with this section shall be counted in determining the limitation of benefits as provided for in paragraphs (2)(a), (3)(c), and (4)(b).

(7)(8) ~~EMPLOYEE LEAVES EMPLOYMENT.~~—If an injured employee, when receiving compensation for temporary partial disability, leaves the employment of the employer by whom she or he was employed at the time of the accident for which such compensation is being paid, the employee shall, upon securing employment elsewhere, give to such former employer an affidavit in writing containing the name of her or his new employer, the place of employment, and the amount of wages being received at such new employment; and, until she or he gives such affidavit, the compensation for temporary partial disability will cease. The employer by whom such employee was employed at the time of the accident for which such compensation is being paid may also at any time demand of such employee an addi-

tional affidavit in writing containing the name of her or his employer, the place of her or his employment, and the amount of wages she or he is receiving; and if the employee, upon such demand, fails or refuses to make and furnish such affidavit, her or his right to compensation for temporary partial disability shall cease until such affidavit is made and furnished. If the employee leaves her or his employment while receiving temporary partial benefits without just cause as determined by the judge of compensation claims, temporary partial benefits shall be payable based on the deemed earnings of the employee as if she or he had remained employed.

~~(8)~~⁽⁹⁾ EMPLOYEE BECOMES INMATE OF INSTITUTION.—In case an employee becomes an inmate of a public institution, then no compensation shall be payable unless she or he has dependent upon her or him for support a person or persons defined as dependents elsewhere in this chapter, whose dependency shall be determined as if the employee were deceased and to whom compensation would be paid in case of death; and such compensation as is due such employee shall be paid such dependents during the time she or he remains such inmate.

~~(9)~~⁽¹⁰⁾ EMPLOYEE ELIGIBLE FOR BENEFITS UNDER THIS CHAPTER AND FEDERAL OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE ACT.—

(a) Weekly compensation benefits payable under this chapter for disability resulting from injuries to an employee who becomes eligible for benefits under 42 U.S.C. s. 423 shall be reduced to an amount whereby the sum of such compensation benefits payable under this chapter and such total benefits otherwise payable for such period to the employee and her or his dependents, had such employee not been entitled to benefits under this chapter, under 42 U.S.C. ss. 402 and 423, does not exceed 80 percent of the employee's average weekly wage. However, this provision shall not operate to reduce an injured worker's benefits under this chapter to a greater extent than such benefits would have otherwise been reduced under 42 U.S.C. s. 424(a). This reduction of compensation benefits is not applicable to any compensation benefits payable for any week subsequent to the week in which the injured worker reaches the age of 62 years.

(b) If the provisions of 42 U.S.C. s. 424(a) are amended to provide for a reduction or increase of the percentage of average current earnings that the sum of compensation benefits payable under this chapter and the benefits payable under 42 U.S.C. ss. 402 and 423 can equal, the amount of the reduction of benefits provided in this subsection shall be reduced or increased accordingly. The department may by rule specify forms and procedures governing the method for calculating and administering the offset of benefits payable under this chapter and benefits payable under 42 U.S.C. ss. 402 and 423. The department shall have first priority in taking any available social security offsets on dates of accidents occurring before July 1, 1984.

(c) No disability compensation benefits payable for any week, including those benefits provided by paragraph (1)(f), shall be reduced pursuant to this subsection until the Social Security Administration determines the amount

otherwise payable to the employee under 42 U.S.C. ss. 402 and 423 and the employee has begun receiving such social security benefit payments. The employee shall, upon demand by the department, the employer, or the carrier, authorize the Social Security Administration to release disability information relating to her or him and authorize the Division of Unemployment Compensation to release unemployment compensation information relating to her or him, in accordance with rules to be adopted by the department prescribing the procedure and manner for requesting the authorization and for compliance by the employee. Neither the department nor the employer or carrier shall make any payment of benefits for total disability or those additional benefits provided by paragraph (1)(f) for any period during which the employee willfully fails or refuses to authorize the release of information in the manner and within the time prescribed by such rules. The authority for release of disability information granted by an employee under this paragraph shall be effective for a period not to exceed 12 months, such authority to be renewable as the department may prescribe by rule.

(d) If compensation benefits are reduced pursuant to this subsection, the minimum compensation provisions of s. 440.12(2) do not apply.

~~(10)~~(11) EMPLOYEE ELIGIBLE FOR BENEFITS UNDER THIS CHAPTER WHO HAS RECEIVED OR IS ENTITLED TO RECEIVE UNEMPLOYMENT COMPENSATION.—

(a) No compensation benefits shall be payable for temporary total disability or permanent total disability under this chapter for any week in which the injured employee has received, or is receiving, unemployment compensation benefits.

(b) If an employee is entitled to temporary partial benefits pursuant to subsection (4) and unemployment compensation benefits, such unemployment compensation benefits shall be primary and the temporary partial benefits shall be supplemental only, the sum of the two benefits not to exceed the amount of temporary partial benefits which would otherwise be payable.

~~(11)~~(12) FULL-PAY STATUS FOR CERTAIN LAW ENFORCEMENT OFFICERS.—Any law enforcement officer as defined in s. 943.10(1), (2), or (3) who, while acting within the course of employment as provided by s. 440.091, is maliciously or intentionally injured and who thereby sustains a job-connected disability compensable under this chapter shall be carried in full-pay status rather than being required to use sick, annual, or other leave. Full-pay status shall be granted only after submission to the employing agency's head of a medical report which gives a current diagnosis of the employee's recovery and ability to return to work. In no case shall the employee's salary and workers' compensation benefits exceed the amount of the employee's regular salary requirements.

~~(12)~~(13) REPAYMENT.—If an employee has received a sum as an indemnity benefit under any classification or category of benefit under this chapter to which she or he is not entitled, the employee is liable to repay that sum to the employer or the carrier or to have that sum deducted from future benefits, regardless of the classification of benefits, payable to the employee

under this chapter; however, a partial payment of the total repayment may not exceed 20 percent of the amount of the biweekly payment.

Section 19. Subsections (1), (2), and (3) of section 440.151, Florida Statutes, are amended to read:

440.151 Occupational diseases.—

(1)(a) Where the employer and employee are subject to the provisions of the Workers' Compensation Law, the disablement or death of an employee resulting from an occupational disease as hereinafter defined shall be treated as the happening of an injury by accident, notwithstanding any other provisions of this chapter, and the employee or, in case of death, the employee's dependents shall be entitled to compensation as provided by this chapter, except as hereinafter otherwise provided; and the practice and procedure prescribed by this chapter shall apply to all proceedings under this section, except as hereinafter otherwise provided. Provided, however, that in no case shall an employer be liable for compensation under the provisions of this section unless such disease has resulted from the nature of the employment in which the employee was engaged under such employer, ~~and was actually contracted while so engaged, and the nature of the employment was the major contributing cause of the disease. Major contributing cause must be shown by medical evidence only, as demonstrated by physical examination findings and diagnostic testing. meaning by "Nature of the employment" means that in~~ to the occupation in which the employee was so engaged there is attached a particular hazard of such disease that distinguishes it from the usual run of occupations, or the incidence of such disease is substantially higher in the occupation in which the employee was so engaged than in the usual run of occupations. In claims for death under s. 440.16, death must occur or, in case of death, unless death follows continuous disability from such disease, commencing within the period above limited, for which compensation has been paid or awarded, or timely claim made as provided in this section, and results within 350 weeks after such last exposure. Both causation and sufficient exposure to a specific harmful substance shown to be present in the workplace to support causation shall be proven by clear and convincing evidence.

(b) No compensation shall be payable for an occupational disease if the employee, at the time of entering into the employment of the employer by whom the compensation would otherwise be payable, falsely represents herself or himself in writing as not having previously been disabled, laid off or compensated in damages or otherwise, because of such disease.

(c) Where an occupational disease is aggravated by any other disease or infirmity, not itself compensable, or where disability or death from any other cause, not itself compensable, is aggravated, prolonged, accelerated or in anywise contributed to by an occupational disease, the compensation shall be payable only if the occupational disease is the major contributing cause of the injury. Any compensation shall be reduced and limited to such proportion only of the compensation that would be payable if the occupational disease were the sole cause of the disability or death as such occupational disease, as a causative factor, bears to all the causes of such disability or

death, such reduction in compensation to be effected by reducing the number of weekly or monthly payments or the amounts of such payments, as under the circumstances of the particular case may be for the best interest of the claimant or claimants. Major contributing cause must be demonstrated by medical evidence based on physical examination findings and diagnostic testing.

(d) No compensation for death from an occupational disease shall be payable to any person whose relationship to the deceased, which under the provisions of this Workers' Compensation Law would give right to compensation, arose subsequent to the beginning of the first compensable disability, save only to afterborn children of a marriage existing at the beginning of such disability.

(e) No compensation shall be payable for disability or death resulting from tuberculosis arising out of and in the course of employment by the Department of Health at a state tuberculosis hospital, or aggravated by such employment, when the employee had suffered from said disease at any time prior to the commencement of such employment.

(2) Whenever used in this section the term "occupational disease" shall be construed to mean only a disease which is due to causes and conditions which are characteristic of and peculiar to a particular trade, occupation, process, or employment, and to exclude all ordinary diseases of life to which the general public is exposed, unless the incidence of the disease is substantially higher in the particular trade, occupation, process, or employment than for the general public. "Occupational disease" means only a disease for which there are epidemiological studies showing that exposure to the specific substance involved, at the levels to which the employee was exposed, may cause the precise disease sustained by the employee.

(3) Except as ~~hereinafter~~ otherwise provided in this section, "disablement" means disability as described in s. 440.02(13) the event of an employee's becoming actually incapacitated, partially or totally, because of an occupational disease, from performing her or his work in the last occupation in which injuriously exposed to the hazards of such disease; and "disability" means the state of being so incapacitated.

Section 20. Subsections (1) and (7) of section 440.16, Florida Statutes, are amended to read:

440.16 Compensation for death.—

(1) If death results from the accident within 1 year thereafter or follows continuous disability and results from the accident within 5 years thereafter, the employer shall pay:

(a) Within 14 days after receiving the bill, actual funeral expenses not to exceed \$7,500 ~~\$5,000~~.

(b) Compensation, in addition to the above, in the following percentages of the average weekly wages to the following persons entitled thereto on account of dependency upon the deceased, and in the following order of

preference, subject to the limitation provided in subparagraph 2., but such compensation shall be subject to the limits provided in s. 440.12(2), shall not exceed ~~\$150,000~~ \$100,000, and may be less than, but shall not exceed, for all dependents or persons entitled to compensation, 66⅔ percent of the average wage:

1. To the spouse, if there is no child, 50 percent of the average weekly wage, such compensation to cease upon the spouse's death.

2. To the spouse, if there is a child or children, the compensation payable under subparagraph 1. and, in addition, 16⅔ percent on account of the child or children. However, when the deceased is survived by a spouse and also a child or children, whether such child or children are the product of the union existing at the time of death or of a former marriage or marriages, the judge of compensation claims may provide for the payment of compensation in such manner as may appear to the judge of compensation claims just and proper and for the best interests of the respective parties and, in so doing, may provide for the entire compensation to be paid exclusively to the child or children; and, in the case of death of such spouse, 33⅓ percent for each child. However, upon the surviving spouse's remarriage, the spouse shall be entitled to a lump-sum payment equal to 26 weeks of compensation at the rate of 50 percent of the average weekly wage as provided in s. 440.12(2), unless the ~~\$150,000~~ \$100,000 limit provided in this paragraph is exceeded, in which case the surviving spouse shall receive a lump-sum payment equal to the remaining available benefits in lieu of any further indemnity benefits. In no case shall a surviving spouse's acceptance of a lump-sum payment affect payment of death benefits to other dependents.

3. To the child or children, if there is no spouse, 33⅓ percent for each child.

4. To the parents, 25 percent to each, such compensation to be paid during the continuance of dependency.

5. To the brothers, sisters, and grandchildren, 15 percent for each brother, sister, or grandchild.

(c) To the surviving spouse, payment of postsecondary student fees for instruction at any area technical center established under s. 1001.44 for up to 1,800 classroom hours or payment of student fees at any community college established under part III of chapter 1004 for up to 80 semester hours. The spouse of a deceased state employee shall be entitled to a full waiver of such fees as provided in ss. 1009.22 and 1009.23 in lieu of the payment of such fees. The benefits provided for in this paragraph shall be in addition to other benefits provided for in this section and shall terminate 7 years after the death of the deceased employee, or when the total payment in eligible compensation under paragraph (b) has been received. To qualify for the educational benefit under this paragraph, the spouse shall be required to meet and maintain the regular admission requirements of, and be registered at, such area technical center or community college, and make satisfactory academic progress as defined by the educational institution in which the student is enrolled.

(7) Compensation under this chapter to aliens not residents (or about to become nonresidents) of the United States or Canada shall be the same in amount as provided for residents, except that dependents in any foreign country shall be limited to surviving spouse and child or children, or if there be no surviving spouse or child or children, to surviving father or mother whom the employee has supported, either wholly or in part, for the period of 1 year prior to the date of the injury, and except that the judge of compensation claims may, at the option of the judge of compensation claims, or upon the application of the insurance carrier, commute all future installments of compensation to be paid to such aliens by paying or causing to be paid to them one-half of the commuted amount of such future installments of compensation as determined by the judge of compensation claims, and provided further that compensation to dependents referred to in this subsection shall in no case exceed ~~\$75,000~~ \$50,000.

Section 21. Subsection (9) of section 440.185, Florida Statutes, is amended, and subsection (12) is added to said section, to read:

440.185 Notice of injury or death; reports; penalties for violations.—

(9) Any employer or carrier who fails or refuses to timely send any form, report, or notice required by this section shall be subject to an administrative fine by the department ~~a civil penalty~~ not to exceed \$1,000 ~~\$500~~ for each such failure or refusal. If, within 1 calendar year, an employer fails to timely submit to the carrier more than 10 percent of its notices of injury or death, the employer shall be subject to an administrative fine by the department not to exceed \$2,000 for each such failure or refusal. However, any employer who fails to notify the carrier of the injury on the prescribed form or by letter within the 7 days required in subsection (2) shall be liable for the administrative fine ~~civil penalty~~, which shall be paid by the employer and not the carrier. Failure by the employer to meet its obligations under subsection (2) shall not relieve the carrier from liability for the administrative fine ~~civil penalty~~ if it fails to comply with subsections (4) and (5).

(12) Upon receiving notice of an injury from an employee under subsection (1), the employer or carrier shall provide the employee with a written notice, in the form and manner determined by the department by rule, of the availability of services from the Employee Assistance and Ombudsman Office. The substance of the notice to the employee shall include:

(a) A description of the scope of services provided by the office.

(b) A listing of the toll-free telephone number of, the email address, and the postal address of the office.

(c) A statement that the informational brochure referred to in subsection (4) will be mailed to the employee within 3 days after the carrier receives notice of the injury.

(d) Any other information regarding access to assistance that the department finds is immediately necessary for an injured employee.

Section 22. Subsections (1) and (2) of section 440.192, Florida Statutes, are amended, and subsection (9) is added to said section, to read:

440.192 Procedure for resolving benefit disputes.—

(1) ~~Subject to s. 440.191, Any employee may, for any benefit that is ripe, due, and owing, who has not received a benefit to which the employee believes she or he is entitled under this chapter shall file by certified mail, or by electronic means approved by the Deputy Chief Judge, with the Office of the Judges of Compensation Claims a petition for benefits which meets the requirements of this section and the definition of specificity in s. 440.02.~~ The department shall inform employees of the location of the Office of the Judges of Compensation Claims for purposes of filing a petition for benefits. The employee shall also serve copies of the petition for benefits by certified mail, or by electronic means approved by the Deputy Chief Judge, upon the employer and the employer's carrier. The ~~Deputy~~ Chief Judge shall refer the petitions to the judges of compensation claims.

(2) Upon receipt, the Office of the Judges of Compensation Claims shall review each petition and shall dismiss each petition or any portion of such a petition, ~~upon the judge's own motion or upon the motion of any party,~~ that does not on its face specifically identify or itemize the following:

(a) Name, address, telephone number, and social security number of the employee.

(b) Name, address, and telephone number of the employer.

(c) A detailed description of the injury and cause of the injury, including the location of the occurrence and the date or dates of the accident.

(d) A detailed description of the employee's job, work responsibilities, and work the employee was performing when the injury occurred.

(e) The time period for which compensation and the specific classification of compensation were not timely provided.

(f) Date of maximum medical improvement, character of disability, and specific statement of all benefits or compensation that the employee is seeking.

(g) All specific travel costs to which the employee believes she or he is entitled, including dates of travel and purpose of travel, means of transportation, and mileage and including the date the request for mileage was filed with the carrier and a copy of the request filed with the carrier.

(h) Specific listing of all medical charges alleged unpaid, including the name and address of the medical provider, the amounts due, and the specific dates of treatment.

(i) The type or nature of treatment care or attendance sought and the justification for such treatment. If the employee is under the care of a physician for an injury identified under paragraph (c), a copy of the physician's request, authorization, or recommendation for treatment, care, or attendance must accompany the petition.

(j) Specific explanation of any other disputed issue that a judge of compensation claims will be called to rule upon.

The dismissal of any petition or portion of such a petition under this section is without prejudice and does not require a hearing.

(9) A petition for benefits must contain claims for all benefits that are ripe, due, and owing on the date the petition is filed. Unless stipulated in writing by the parties, only claims which have been properly raised in a petition for benefits and have undergone mediation may be considered for adjudication by a judge of compensation claims.

Section 23. Section 440.1926, Florida Statutes, is created to read:

440.1926 Alternate dispute resolution; claim arbitration.—Notwithstanding any other provision of this chapter, the employer, carrier, and employee may mutually agree to seek consent from a judge of compensation claims to enter into binding claim arbitration in lieu of any other remedy provided for in this chapter to resolve all issues in dispute regarding an injury. Arbitrations agreed to pursuant to this section shall be governed by chapter 682, the Florida Arbitration Code, except that, notwithstanding any provision in chapter 682, the term “court” shall mean a judge of compensation claims. An arbitration award in accordance with this section shall be enforceable in the same manner and with the same powers as any final compensation order.

Section 24. Subsections (2), (3), (4), (6), and (8) and paragraph (d) of subsection (11) of section 440.20, Florida Statutes, are amended to read:

440.20 Time for payment of compensation and medical bills; penalties for late payment.—

(2)(a) The carrier must pay the first installment of compensation for total disability or death benefits or deny compensability no later than the 14th calendar day after the employer receives notification notice of the injury or death, when disability is immediate and continuous for 8 calendar days or more after the injury. If the first 7 days after disability are nonconsecutive or delayed, the first installment of compensation is due on the 6th day after the first 8 calendar days of disability. The carrier shall thereafter pay compensation in biweekly installments or as otherwise provided in s. 440.15, unless the judge of compensation claims determines or the parties agree that an alternate installment schedule is in the best interests of the employee.

(b) The carrier must pay, disallow, or deny all medical, dental, pharmacy, and hospital bills submitted to the carrier in accordance with department rule no later than 45 calendar days after the carrier’s receipt of the bill.

(3) Upon making initial payment of indemnity benefits, or upon suspension or cessation of payment for any reason, the carrier shall immediately notify the injured employee, the employer, and the department that it has commenced, suspended, or ceased payment of compensation. The department may require such notification to the injured employee, employer, and

the department in a any format and manner it deems necessary to obtain accurate and timely notification reporting.

(4) If the carrier is uncertain of its obligation to provide all benefits or compensation, ~~it may initiate payment without prejudice and without admitting liability.~~ the carrier shall immediately and in good faith commence investigation of the employee's entitlement to benefits under this chapter and shall admit or deny compensability within 120 days after the initial provision of compensation or benefits as required under subsection (2) or s. 440.192(8). Additionally, the carrier shall initiate payment and continue the provision of all benefits and compensation as if the claim had been accepted as compensable, without prejudice and without admitting liability. Upon commencement of payment as required under subsection (2) or s. 440.192(8), the carrier shall provide written notice to the employee that it has elected to pay ~~all or part of~~ the claim pending further investigation, and that it will advise the employee of claim acceptance or denial within 120 days. A carrier that fails to deny compensability within 120 days after the initial provision of benefits or payment of compensation as required under subsection (2) or s. 440.192(8) waives the right to deny compensability, unless the carrier can establish material facts relevant to the issue of compensability that it could not have discovered through reasonable investigation within the 120-day period. The initial provision of compensation or benefits, for purposes of this subsection, means the first installment of compensation or benefits to be paid by the carrier under subsection (2) or pursuant to a petition for benefits under s. 440.192(8).

(6)(a) If any installment of compensation for death or dependency benefits, or compensation for disability benefits, ~~permanent impairment, or wage loss~~ payable without an award is not paid within 7 days after it becomes due, as provided in subsection (2), subsection (3), or subsection (4), there shall be added to such unpaid installment a ~~punitive~~ penalty of an amount equal to 20 percent of the unpaid installment ~~or \$5,~~ which shall be paid at the same time as, but in addition to, such installment of compensation. This penalty shall not apply for late payments resulting, unless notice is filed under subsection (4) or unless such nonpayment results from conditions over which the employer or carrier had no control. When any installment of compensation payable without an award has not been paid within 7 days after it became due and the claimant concludes the prosecution of the claim before a judge of compensation claims without having specifically claimed additional compensation in the nature of a penalty under this section, the claimant will be deemed to have acknowledged that, owing to conditions over which the employer or carrier had no control, such installment could not be paid within the period prescribed for payment and to have waived the right to claim such penalty. However, during the course of a hearing, the judge of compensation claims shall on her or his own motion raise the question of whether such penalty should be awarded or excused. The department may assess without a hearing the ~~punitive~~ penalty against either the employer or the ~~insurance~~ carrier, depending upon who was at fault in causing the delay. The insurance policy cannot provide that this sum will be paid by the carrier if the department or the judge of compensation claims determines that the ~~punitive~~ penalty should be ~~paid made~~ by the employer rather than the carrier. Any additional installment of compensation paid by the carrier

pursuant to this section shall be paid directly to the employee by check or, if authorized by the employee, by direct deposit into the employee's account at a financial institution. ~~As used in this subsection, the term "financial institution" means a financial institution as defined in s. 655.005(1)(h).~~

(b) For medical services provided on or after January 1, 2004, the department shall require that all medical, hospital, pharmacy, or dental bills properly submitted by the provider, except for bills that are disallowed or denied by the carrier or its authorized vendor in accordance with department rule, are timely paid within 45 calendar days after the carrier's receipt of the bill. The department shall impose penalties for late payments or disallowances or denials of medical, hospital, pharmacy, or dental bills that are below a minimum 95 percent timely performance standard. The carrier shall pay to the Workers' Compensation Administration Trust Fund a penalty of:

1. Twenty-five dollars for each bill below the 95 percent timely performance standard, but meeting a 90 percent timely standard.

2. Fifty dollars for each bill below a 90 percent timely performance standard.

(8)(a) In addition to any other penalties provided by this chapter for late payment, if any installment of compensation is not paid when it becomes due, the employer, carrier, or servicing agent shall pay interest thereon at the rate of 12 percent per year from the date the installment becomes due until it is paid, whether such installment is payable without an order or under the terms of an order. The interest payment shall be the greater of the amount of interest due or \$5.

~~(a) Within 30 days after final payment of compensation has been made, the employer, carrier, or servicing agent shall send to the department a notice, in accordance with a format and manner prescribed by the department, stating that such final payment has been made and stating the total amount of compensation paid, the name of the employee and of any other person to whom compensation has been paid, the date of the injury or death, and the date to which compensation has been paid.~~

~~(b) If the employer, carrier, or servicing agent fails to so notify the department within such time, the department shall assess against such employer, carrier, or servicing agent a civil penalty in an amount not over \$100.~~

(b)(c) In order to ensure carrier compliance under this chapter and provisions of the Florida Insurance Code, the office department shall monitor, audit, and investigate the performance of carriers by conducting market conduct examinations, as provided in s. 624.3161, and conducting investigations, as provided in s. 624.317. The office department shall require establish by rule minimum performance standards for carriers to ensure that a minimum of 90 percent of all compensation benefits are timely paid in accordance with this section. The office department shall impose penalties fine a carrier as provided in s. 440.13(11)(b) up to \$50 for each late payments payment of compensation that are is below a the minimum 95 90 percent

timely payment performance standard. The carrier shall pay to the Workers' Compensation Administration Trust Fund a penalty of:

1. Fifty dollars per number of installments of compensation below the 95 percent timely payment performance standard and equal to or greater than a 90 percent timely payment performance standard.

2. One hundred dollars per number of installments of compensation below a 90 percent timely payment performance standard.

This section does not affect the imposition of any penalties or interest due to the claimant. If a carrier contracts with a servicing agent to fulfill its administrative responsibilities under this chapter, the payment practices of the servicing agent are deemed the payment practices of the carrier for the purpose of assessing penalties against the carrier.

(11)

(d)1. With respect to any lump-sum settlement under this subsection, a judge of compensation claims must consider at the time of the settlement, whether the settlement allocation provides for the appropriate recovery of child support arrearages. An employer or carrier does not have a duty to investigate or collect information regarding child support arrearages.

2. When reviewing any settlement of lump-sum payment pursuant to this subsection, judges of compensation claims shall consider the interests of the worker and the worker's family when approving the settlement, which must consider and provide for appropriate recovery of past due support.

3. With respect to any lump-sum settlement under this subsection, any correspondence to a clerk of the circuit court of this state regarding child support documentation shall be exempt from any fees or costs ordinarily assessed by the clerk's office.

Section 25. Section 440.25, Florida Statutes, is amended to read:

440.25 Procedures for mediation and hearings.—

(1) ~~Forty days~~ ~~Within 90 days~~ after a petition for benefits is filed under s. 440.192, ~~a mediation conference concerning such petition shall be held. Within 40 days after such petition is filed,~~ the judge of compensation claims shall notify the interested parties by order that a mediation conference concerning such petition ~~has been scheduled will be held~~ unless the parties have notified the ~~judge~~ ~~Office of the Judges~~ of compensation claims that a private mediation has been held or is scheduled to be held. A mediation, whether private or public, shall be held within 130 days after the filing of the petition. Such order must give the date ~~by which~~ the mediation conference ~~is to~~ ~~must~~ be held. Such order may be served personally upon the interested parties or may be sent to the interested parties by mail. If multiple petitions are pending, or if additional petitions are filed after the scheduling of a mediation, the judge of compensation claims shall consolidate all petitions into one mediation. The claimant or the adjuster of the employer or carrier may, at the mediator's discretion, attend the mediation conference

by telephone or, if agreed to by the parties, other electronic means. A continuance may be granted upon the agreement of the parties or if the requesting party demonstrates to the judge of compensation claims that the reason for requesting the continuance arises from circumstances beyond the party's control. Any order granting a continuance must set forth the date of the rescheduled mediation conference. A mediation conference may not be used solely for the purpose of mediating attorney's fees.

(2) Any party who participates in a mediation conference shall not be precluded from requesting a hearing following the mediation conference should both parties not agree to be bound by the results of the mediation conference. A mediation conference is required to be held unless this requirement is waived by the Deputy Chief Judge. ~~No later than 3 days prior to the mediation conference, all parties must submit any applicable motions, including, but not limited to, a motion to waive the mediation conference, to the judge of compensation claims.~~

(3)(a) Such mediation conference shall be conducted informally and does not require the use of formal rules of evidence or procedure. Any information from the files, reports, case summaries, mediator's notes, or other communications or materials, oral or written, relating to a mediation conference under this section obtained by any person performing mediation duties is privileged and confidential and may not be disclosed without the written consent of all parties to the conference. Any research or evaluation effort directed at assessing the mediation program activities or performance must protect the confidentiality of such information. Each party to a mediation conference has a privilege during and after the conference to refuse to disclose and to prevent another from disclosing communications made during the conference whether or not the contested issues are successfully resolved. This subsection and paragraphs (4)(a) and (b) shall not be construed to prevent or inhibit the discovery or admissibility of any information that is otherwise subject to discovery or that is admissible under applicable law or rule of procedure, except that any conduct or statements made during a mediation conference or in negotiations concerning the conference are inadmissible in any proceeding under this chapter.

~~(a)1.~~ (a)1. Unless the parties conduct a private mediation under paragraph (b) subparagraph 2., mediation shall be conducted by a mediator selected by the Director of the Division of Administrative Hearings from among mediators employed on a full-time basis by the Office of the Judges of Compensation Claims. A mediator must be a member of The Florida Bar for at least 5 years and must complete a mediation training program approved by the Deputy Chief Judge Director of the Division of Administrative Hearings. Adjunct mediators may be employed by the Office of the Judges of Compensation Claims on an as-needed basis and shall be selected from a list prepared by the Director of the Division of Administrative Hearings. An adjunct mediator must be independent of all parties participating in the mediation conference. An adjunct mediator must be a member of The Florida Bar for at least 5 years and must complete a mediation training program approved by the Office of the Judges of Compensation Claims Director of the Division of Administrative Hearings. An adjunct mediator shall have access to the

office, equipment, and supplies of the judge of compensation claims in each district.

~~(b)2.~~ With respect to any private mediation occurring on or after January 1, 2003, if the parties agree or if mediators are not available under paragraph (a), pursuant to notice from the judge of compensation claims, subparagraph 1. to conduct the required mediation within the period specified in this section, the parties shall hold a mediation conference at the carrier's expense within the 130-day 90-day period set for mediation. The mediation conference shall be conducted by a mediator certified under s. 44.106. If the parties do not agree upon a mediator within 10 days after the date of the order, the claimant shall notify the judge in writing and the judge shall appoint a mediator under this subparagraph within 7 days. In the event both parties agree, the results of the mediation conference shall be binding and neither party shall have a right to appeal the results. In the event either party refuses to agree to the results of the mediation conference, the results of the mediation conference as well as the testimony, witnesses, and evidence presented at the conference shall not be admissible at any subsequent proceeding on the claim. The mediator shall not be called in to testify or give deposition to resolve any claim for any hearing before the judge of compensation claims. The employer may be represented by an attorney at the mediation conference if the employee is also represented by an attorney at the mediation conference.

~~(b) The parties shall complete the pretrial stipulations before the conclusion of the mediation conference if the claims, except for attorney's fees and costs, have not been settled and if any claims in any filed petition remain unresolved. The judge of compensation claims may impose sanctions against a party or both parties for failing to complete the pretrial stipulations before the conclusion of the mediation conference.~~

~~(4)(a) If the parties fail to agree to upon written submission of pretrial stipulations at the mediation conference, the judge of compensation claims shall conduct a live order a pretrial hearing to occur within 14 days after the date of mediation ordered by the judge of compensation claims. The judge of compensation claims shall give the interested parties at least 14 7 days' advance notice of the pretrial hearing by mail. At the pretrial hearing, the judge of compensation claims shall, subject to paragraph (b), set a date for the final hearing that allows the parties at least 60 days to conduct discovery unless the parties consent to an earlier hearing date.~~

(b) The final hearing must be held and concluded within 90 days after the mediation conference is held, allowing the parties sufficient time to complete discovery. Except as set forth in this section, continuances may be granted only if the requesting party demonstrates to the judge of compensation claims that the reason for requesting the continuance arises from circumstances beyond the party's control. The written consent of the claimant must be obtained before any request from a claimant's attorney is granted for an additional continuance after the initial continuance has been granted. Any order granting a continuance must set forth the date and time of the rescheduled hearing. A continuance may be granted only if the requesting party demonstrates to the judge of compensation claims that the reason for requesting the continuance arises from circumstances beyond the control of

the parties. The judge of compensation claims shall report any grant of two or more continuances to the Deputy Chief Judge.

(c) The judge of compensation claims shall give the interested parties at least 14 7 days' advance notice of the final hearing, served upon the interested parties by mail.

(d) The final hearing shall be held within 210 days after receipt of the petition for benefits in the county where the injury occurred, if the injury occurred in this state, unless otherwise agreed to between the parties and authorized by the judge of compensation claims in the county where the injury occurred. However, the claimant may waive the timeframes within this section for good cause shown. If the injury occurred outside the state and is one for which compensation is payable under this chapter, then the final hearing may be held in the county of the employer's residence or place of business, or in any other county of the state that will, in the discretion of the Deputy Chief Judge, be the most convenient for a hearing. The final hearing shall be conducted by a judge of compensation claims, who shall, within 30 days after final hearing or closure of the hearing record, unless otherwise agreed by the parties, enter a final order on the merits of the disputed issues. The judge of compensation claims may enter an abbreviated final order in cases in which compensability is not disputed. Either party may request separate findings of fact and conclusions of law. At the final hearing, the claimant and employer may each present evidence with respect to the claims presented by the petition for benefits and may be represented by any attorney authorized in writing for such purpose. When there is a conflict in the medical evidence submitted at the hearing, the provisions of s. 440.13 shall apply. The report or testimony of the expert medical advisor shall be admitted into evidence in a made a part of the record of the proceeding and shall be given the same consideration by the judge of compensation claims as is accorded other medical evidence submitted in the proceeding; and all costs incurred in connection with such examination and testimony may be assessed as costs in the proceeding, subject to the provisions of s. 440.13. No judge of compensation claims may make a finding of a degree of permanent impairment that is greater than the greatest permanent impairment rating given the claimant by any examining or treating physician, except upon stipulation of the parties. Any benefit due but not raised at the final hearing which was ripe, due, or owing at the time of the final hearing is waived.

(e) The order making an award or rejecting the claim, referred to in this chapter as a "compensation order," shall set forth the findings of ultimate facts and the mandate; and the order need not include any other reason or justification for such mandate. The compensation order shall be filed in the Office of the Judges of Compensation Claims at Tallahassee. A copy of such compensation order shall be sent by mail to the parties and attorneys of record at the last known address of each, with the date of mailing noted thereon.

~~(f) Each judge of compensation claims is required to submit a special report to the Deputy Chief Judge in each contested workers' compensation case in which the case is not determined within 30 days of final hearing or~~

~~closure of the hearing record. Said form shall be provided by the director of the Division of Administrative Hearings and shall contain the names of the judge of compensation claims and of the attorneys involved and a brief explanation by the judge of compensation claims as to the reason for such a delay in issuing a final order.~~

(f)(g) Notwithstanding any other provision of this section, the judge of compensation claims may require the appearance of the parties and counsel before her or him without written notice for an emergency conference where there is a bona fide emergency involving the health, safety, or welfare of an employee. An emergency conference under this section may result in the entry of an order or the rendering of an adjudication by the judge of compensation claims.

(g)(h) To expedite dispute resolution and to enhance the self-executing features of the Workers' Compensation Law, the Deputy Chief Judge shall make provision by rule or order for the resolution of appropriate motions by judges of compensation claims without oral hearing upon submission of brief written statements in support and opposition, and for expedited discovery and docketing. Unless the judge of compensation claims, for good cause, orders a hearing under paragraph (h)(i), each claim in a petition relating to the determination of the average weekly wage pay under s. 440.14 shall be resolved under this paragraph without oral hearing.

(h)(i) To further expedite dispute resolution and to enhance the self-executing features of the system, those petitions filed in accordance with s. 440.192 that involve a claim for benefits of \$5,000 or less shall, in the absence of compelling evidence to the contrary, be presumed to be appropriate for expedited resolution under this paragraph; and any other claim filed in accordance with s. 440.192, upon the written agreement of both parties and application by either party, may similarly be resolved under this paragraph. A claim in a petition or \$5,000 or less for medical benefits only or a petition for reimbursement for mileage for medical purposes shall, in the absence of compelling evidence to the contrary, be resolved through the expedited dispute resolution process provided in this paragraph. For purposes of expedited resolution pursuant to this paragraph, the Deputy Chief Judge shall make provision by rule or order for expedited and limited discovery and expedited docketing in such cases. At least 15 days prior to hearing, the parties shall exchange and file with the judge of compensation claims a pretrial outline of all issues, defenses, and witnesses on a form adopted by the Deputy Chief Judge; provided, in no event shall such hearing be held without 15 days' written notice to all parties. No pretrial hearing shall be held and no mediation scheduled unless requested by a party. The judge of compensation claims shall limit all argument and presentation of evidence at the hearing to a maximum of 30 minutes, and such hearings shall not exceed 30 minutes in length. Neither party shall be required to be represented by counsel. The employer or carrier may be represented by an adjuster or other qualified representative. The employer or carrier and any witness may appear at such hearing by telephone. The rules of evidence shall be liberally construed in favor of allowing introduction of evidence.

(i)(j) A judge of compensation claims may, upon the motion of a party or the judge's own motion, dismiss a petition for lack of prosecution if a peti-

tion, response, motion, order, request for hearing, or notice of deposition has not been filed during the previous 12 months unless good cause is shown. A dismissal for lack of prosecution is without prejudice and does not require a hearing.

~~(j)~~^(k) A judge of compensation claims may not award interest on unpaid medical bills and the amount of such bills may not be used to calculate the amount of interest awarded. Regardless of the date benefits were initially requested, attorney's fees do not attach under this subsection until 30 days after the date the carrier or self-insured employer receives the petition.

(5)(a) Procedures with respect to appeals from orders of judges of compensation claims shall be governed by rules adopted by the Supreme Court. Such an order shall become final 30 days after mailing of copies of such order to the parties, unless appealed pursuant to such rules.

(b) An appellant may be relieved of any necessary filing fee by filing a verified petition of indigency for approval as provided in s. 57.081(1) and may be relieved in whole or in part from the costs for preparation of the record on appeal if, within 15 days after the date notice of the estimated costs for the preparation is served, the appellant files with the judge of compensation claims a copy of the designation of the record on appeal, and a verified petition to be relieved of costs. A verified petition filed prior to the date of service of the notice of the estimated costs shall be deemed not timely filed. The verified petition relating to record costs shall contain a sworn statement that the appellant is insolvent and a complete, detailed, and sworn financial affidavit showing all the appellant's assets, liabilities, and income. Failure to state in the affidavit all assets and income, including marital assets and income, shall be grounds for denying the petition with prejudice. The Office of the Judges of Compensation Claims shall adopt rules as may be required pursuant to this subsection, including forms for use in all petitions brought under this subsection. The appellant's attorney, or the appellant if she or he is not represented by an attorney, shall include as a part of the verified petition relating to record costs an affidavit or affirmation that, in her or his opinion, the notice of appeal was filed in good faith and that there is a probable basis for the District Court of Appeal, First District, to find reversible error, and shall state with particularity the specific legal and factual grounds for the opinion. Failure to so affirm shall be grounds for denying the petition. A copy of the verified petition relating to record costs shall be served upon all interested parties. The judge of compensation claims shall promptly conduct a hearing on the verified petition relating to record costs, giving at least 15 days' notice to the appellant, the department, and all other interested parties, all of whom shall be parties to the proceedings. The judge of compensation claims may enter an order without such hearing if no objection is filed by an interested party within 20 days from the service date of the verified petition relating to record costs. Such proceedings shall be conducted in accordance with the provisions of this section and with the workers' compensation rules of procedure, to the extent applicable. In the event an insolvency petition is granted, the judge of compensation claims shall direct the department to pay record costs and filing fees from the Workers' Compensation Administration Trust Fund

pending final disposition of the costs of appeal. The department may transcribe or arrange for the transcription of the record in any proceeding for which it is ordered to pay the cost of the record.

(c) As a condition of filing a notice of appeal to the District Court of Appeal, First District, an employer who has not secured the payment of compensation under this chapter in compliance with s. 440.38 shall file with the notice of appeal a good and sufficient bond, as provided in s. 59.13, conditioned to pay the amount of the demand and any interest and costs payable under the terms of the order if the appeal is dismissed, or if the District Court of Appeal, First District, affirms the award in any amount. Upon the failure of such employer to file such bond with ~~the judge of compensation claims or~~ the District Court of Appeal, First District, along with the notice of appeal, the District Court of Appeal, First District, shall dismiss the notice of appeal.

(6) An award of compensation for disability may be made after the death of an injured employee.

~~(7) An injured employee claiming or entitled to compensation shall submit to such physical examination by a certified expert medical advisor approved by the agency or the judge of compensation claims as the agency or the judge of compensation claims may require. The place or places shall be reasonably convenient for the employee. Such physician or physicians as the employee, employer, or carrier may select and pay for may participate in an examination if the employee, employer, or carrier so requests. Proceedings shall be suspended and no compensation shall be payable for any period during which the employee may refuse to submit to examination. Any interested party shall have the right in any case of death to require an autopsy, the cost thereof to be borne by the party requesting it; and the judge of compensation claims shall have authority to order and require an autopsy and may, in her or his discretion, withhold her or his findings and award until an autopsy is held.~~

Section 26. Subsections (1), (2), and (3) of section 440.34, Florida Statutes, are amended, and subsection (7) is added to said section, to read:

440.34 Attorney's fees; costs.—

(1) A fee, gratuity, or other consideration may not be paid for ~~services rendered~~ for a claimant in connection with any proceedings arising under this chapter, unless approved as reasonable by the judge of compensation claims or court having jurisdiction over such proceedings. ~~Except as provided by this subsection,~~ Any attorney's fee approved by a judge of compensation claims for benefits secured on behalf of services rendered to a claimant must equal to 20 percent of the first \$5,000 of the amount of the benefits secured, 15 percent of the next \$5,000 of the amount of the benefits secured, 10 percent of the remaining amount of the benefits secured to be provided during the first 10 years after the date the claim is filed, and 5 percent of the benefits secured after 10 years. The judge of compensation claims shall not approve a compensation order, a joint stipulation for lump-sum settlement, a stipulation or agreement between a claimant and his or her attorney, or any other agreement related to benefits under this chapter that

provides for an attorney's fee in excess of the amount permitted by this section. The judge of compensation claims is not required to approve any retainer agreement between the claimant and his or her attorney. The retainer agreement as to fees and costs may not be for compensation in excess of the amount allowed under this section. However, The judge of compensation claims shall consider the following factors in each case and may increase or decrease the attorney's fee if, in her or his judgment, the circumstances of the particular case warrant such action:

~~(a) The time and labor required, the novelty and difficulty of the questions involved, and the skill requisite to perform the legal service properly.~~

~~(b) The fee customarily charged in the locality for similar legal services.~~

~~(c) The amount involved in the controversy and the benefits resulting to the claimant.~~

~~(d) The time limitation imposed by the claimant or the circumstances.~~

~~(e) The experience, reputation, and ability of the lawyer or lawyers performing services.~~

~~(f) The contingency or certainty of a fee.~~

(2) In awarding a reasonable claimant's attorney's fee, the judge of compensation claims shall consider only those benefits ~~secured by to the claimant that the attorney is responsible for securing.~~ An attorney is not entitled to attorney's fees for representation in any issue that was ripe, due, and owing and that reasonably could have been addressed, but was not addressed, during the pendency of other issues for the same injury. The amount, statutory basis, and type of benefits obtained through legal representation shall be listed on all attorney's fees awarded by the judge of compensation claims. For purposes of this section, the term "benefits secured" ~~means benefits obtained as a result of the claimant's attorney's legal services rendered in connection with the claim for benefits. However, such term does not include future medical benefits to be provided on any date more than 5 years after the date the claim is filed. In the event an offer to settle an issue pending before a judge of compensation claims, including attorney's fees as provided for in this section, is communicated in writing to the claimant or the claimant's attorney at least 30 days prior to the trial date on such issue, for purposes of calculating the amount of attorney's fees to be taxed against the employer or carrier, the term "benefits secured" shall be deemed to include only that amount awarded to the claimant above the amount specified in the offer to settle. If multiple issues are pending before the judge of compensation claims, said offer of settlement shall address each issue pending and shall state explicitly whether or not the offer on each issue is severable. The written offer shall also unequivocally state whether or not it includes medical witness fees and expenses and all other costs associated with the claim.~~

(3) ~~If any party the claimant~~ should prevail in any proceedings before a judge of compensation claims or court, there shall be taxed against the ~~nonprevailing party employer~~ the reasonable costs of such proceedings, not

to include ~~the attorney's fees of the claimant.~~ A claimant shall be responsible for the payment of her or his own attorney's fees, except that a claimant shall be entitled to recover a reasonable attorney's fee from a carrier or employer:

(a) Against whom she or he successfully asserts a petition for medical benefits only, if the claimant has not filed or is not entitled to file at such time a claim for disability, permanent impairment, wage-loss, or death benefits, arising out of the same accident;

(b) In any case in which the employer or carrier files a response to petition denying benefits with the Office of the Judges of Compensation Claims and the injured person has employed an attorney in the successful prosecution of the petition;

(c) In a proceeding in which a carrier or employer denies that an accident occurred for which compensation benefits are payable, and the claimant prevails on the issue of compensability; or

(d) In cases where the claimant successfully prevails in proceedings filed under s. 440.24 or s. 440.28.

Regardless of the date benefits were initially requested, attorney's fees shall not attach under this subsection until 30 days after the date the carrier or employer, if self-insured, receives the petition. ~~In applying the factors set forth in subsection (1) to cases arising under paragraphs (a), (b), (c), and (d), the judge of compensation claims must only consider only such benefits and the time reasonably spent in obtaining them as were secured for the claimant within the scope of paragraphs (a), (b), (c), and (d).~~

(7) If an attorney's fee is owed under paragraph (3)(a), the judge of compensation claims may approve an alternative attorney's fee not to exceed \$1,500 only once per accident, based on a maximum hourly rate of \$150 per hour, if the judge of compensation claims expressly finds that the attorney's fee amount provided for in subsection (1), based on benefits secured, fails to fairly compensate the attorney for disputed medical-only claims as provided in paragraph (3)(a) and the circumstances of the particular case warrant such action.

Section 27. Subsection (7) is added to section 440.38, Florida Statutes, to read:

440.38 Security for compensation; insurance carriers and self-insurers.—

(7) Any employer who meets the requirements of subsection (1) through a policy of insurance issued outside of this state must at all times, with respect to all employees working in this state, maintain the required coverage under a Florida endorsement using Florida rates and rules pursuant to payroll reporting that accurately reflects the work performed in this state by such employees.

Section 28. Subsections (2) and (6) of section 440.381, Florida Statutes, are amended to read:

440.381 Application for coverage; reporting payroll; payroll audit procedures; penalties.—

(2) Submission of an application that contains false, misleading, or incomplete information provided with the purpose of avoiding or reducing the amount of premiums for workers' compensation coverage is a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. The application must contain a statement that the filing of an application containing false, misleading, or incomplete information provided with the purpose of avoiding or reducing the amount of premiums for workers' compensation coverage is a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. The application must contain a sworn statement by the employer attesting to the accuracy of the information submitted and acknowledging the provisions of former s. 440.37(4). The application must contain a sworn statement by the agent attesting that the agent explained to the employer or officer the classification codes that are used for premium calculations.

(6)(a) If an employer understates or conceals payroll, or misrepresents or conceals employee duties so as to avoid proper classification for premium calculations, or misrepresents or conceals information pertinent to the computation and application of an experience rating modification factor, the employer, or the employer's agent or attorney, shall pay to the insurance carrier a penalty of 10 times the amount of the difference in premium paid and the amount the employer should have paid and reasonable attorney's fees. The penalty may be enforced in the circuit courts of this state.

(b) If the department determines that an employer has materially understated or concealed payroll, has materially misrepresented or concealed employee duties so as to avoid proper classification for premium calculations, or has materially misrepresented or concealed information pertinent to the computation and application of an experience rating modification factor, the department shall immediately notify the employer's carrier of such determination. The carrier shall commence a physical onsite audit of the employer within 30 days after receiving notification from the department. If the carrier fails to commence the audit as required by this section, the department shall contract with auditing professionals to conduct the audit at the carrier's expense. A copy of the carrier's audit of the employer shall be provided to the department upon completion. The carrier is not required to conduct the physical onsite audit of the employer as set forth in this paragraph if the carrier gives written notice of cancellation to the employer within 30 days after receiving notification from the department of the material misrepresentation, understatement, or concealment and an audit is conducted in conjunction with the cancellation.

Section 29. Subsection (3) of section 440.42, Florida Statutes, is amended to read:

440.42 Insurance policies; liability.—

(3) No contract or policy of insurance issued by a carrier under this chapter shall expire or be canceled until at least 30 days have elapsed after a notice of cancellation has been sent to the department and to the employer in accordance with the provisions of s. 440.185(7). For cancellation due to nonpayment of premium, the insurer shall mail notification to the employer at least 10 days prior to the effective date of the cancellation. However, when duplicate or dual coverage exists by reason of two different carriers having issued policies of insurance to the same employer securing the same liability, it shall be presumed that only that policy with the later effective date shall be in force and that the earlier policy terminated upon the effective date of the latter. In the event that both policies carry the same effective date, one of the policies may be canceled instanter upon filing a notice of cancellation with the department and serving a copy thereof upon the employer in such manner as the department prescribes by rule. The department may by rule prescribe the content of the notice of retroactive cancellation and specify the time, place, and manner in which the notice of cancellation is to be served.

Section 30. Paragraph (a) of subsection (4) of section 440.49, Florida Statutes, is amended to read:

440.49 Limitation of liability for subsequent injury through Special Disability Trust Fund.—

(4) PERMANENT IMPAIRMENT OR PERMANENT TOTAL DISABILITY, TEMPORARY BENEFITS, MEDICAL BENEFITS, OR ATTENDANT CARE AFTER OTHER PHYSICAL IMPAIRMENT.—

(a) Permanent impairment.—If an employee who has a preexisting permanent physical impairment incurs a subsequent permanent impairment from injury or occupational disease arising out of, and in the course of, her or his employment which merges with the preexisting permanent physical impairment to cause a permanent impairment, the employer shall, in the first instance, pay all benefits provided by this chapter; but, subject to the limitations specified in subsection (6), such employer shall be reimbursed from the Special Disability Trust Fund created by subsection (9) for 50 percent of all impairment benefits which the employer has been required to provide pursuant to s. 440.15(3)~~(a)~~ as a result of the subsequent accident or occupational disease.

Section 31. Subsection (6) of section 440.491, Florida Statutes, is amended to read:

440.491 Reemployment of injured workers; rehabilitation.—

(6) TRAINING AND EDUCATION.—

(a) Upon referral of an injured employee by the carrier, or upon the request of an injured employee, the department shall conduct a training and education screening to determine whether it should refer the employee for a vocational evaluation and, if appropriate, approve training and education or other vocational services for the employee. The department may not approve formal training and education programs unless it determines, after

consideration of the reemployment assessment, pertinent reemployment status reviews or reports, and such other relevant factors as it prescribes by rule, that the reemployment plan is likely to result in return to suitable gainful employment. The department is authorized to expend moneys from the Workers' Compensation Administration Trust Fund, established by s. 440.50, to secure appropriate training and education at a community college established under part III of chapter 240 or at a vocational-technical school established under s. 230.63, or to secure other vocational services when necessary to satisfy the recommendation of a vocational evaluator. As used in this paragraph, "appropriate training and education" includes securing a general education diploma (GED), if necessary. The department shall establish training and education standards pertaining to employee eligibility, course curricula and duration, and associated costs.

(b) ~~When it appears that an employee who has attained maximum medical improvement is unable to earn at least 80 percent of the compensation rate and requires training and education to obtain suitable gainful employment, the employer or carrier shall pay the employee additional training and education temporary total compensation benefits while the employee receives such training and education for a period not to exceed 26 weeks, which period may be extended for an additional 26 weeks or less, if such extended period is determined to be necessary and proper by a judge of compensation claims. The benefits provided under this paragraph shall not be in addition to the 104 weeks as specified in s. 440.15(2). However, a carrier or employer is not precluded from voluntarily paying additional temporary total disability compensation beyond that period. If an employee requires temporary residence at or near a facility or an institution providing training and education which is located more than 50 miles away from the employee's customary residence, the reasonable cost of board, lodging, or travel must be borne by the department from the Workers' Compensation Administration Trust Fund established by s. 440.50. An employee who refuses to accept training and education that is recommended by the vocational evaluator and considered necessary by the department will forfeit any additional training and education benefits and any additional payment for lost wages under this chapter. The department shall adopt rules to implement this section, which shall include requirements placed upon the carrier to notify the injured employee of the availability of training and education benefits as specified in this chapter. The department shall also include information regarding the eligibility for training and education benefits in informational materials specified in ss. 440.207 and 440.40 is subject to a 50-percent reduction in weekly compensation benefits, including wage-loss benefits, as determined under s. 440.15(3)(b).~~

Section 32. Section 440.525, Florida Statutes, is amended to read:

440.525 Examination and investigation of carriers and claims-handling entities.—

(1) ~~The department may examine, or investigate any each carrier, third-party administrator, servicing agent, or other claims-handling entity as often as is warranted to ensure that it is carriers are fulfilling its their obligations under this chapter the law. The examination may cover any period of the carrier's operations since the last previous examination.~~

(2) An examination may cover any period of the carrier's, third-party administrator's, servicing agent's, or other claims-handling entity's operations since the last previous examination. An investigation based upon a reasonable belief by the department that a material violation of this chapter has occurred may cover any time period, but may not predate the last examination by more than 5 years. The department may by rule establish procedures, standards, and protocols for examinations and investigations. If the department finds any violation of this chapter, it may impose administrative penalties pursuant to this chapter. If the department finds any self-insurer in violation of this chapter, it may take action pursuant s. 440.38(3). Examinations or investigations by the department may address, but are not limited to addressing, patterns or practices of unreasonable delay in claims handling; timeliness and accuracy of payments and reports under ss. 440.13, 440.16, and 440.185; or patterns or practices of harassment, coercion, or intimidation of claimants. The department may also specify by rule the documentation to be maintained for each claim file.

(3) As to any examination or investigation conducted under this chapter, the department shall have the power to conduct onsite inspections of claims records and documentation of a carrier, third-party administrator, servicing agent, or other claims-handling entity, and conduct interviews, both sworn and unsworn, of claims-handling personnel. Carriers, third-party administrators, servicing agents, and other claims-handling entities shall make all claims records, documentation, communication, and correspondence available to department personnel during regular business hours. If any person fails to comply with a request for production of records or documents or fails to produce an employee for interview, the department may compel production or attendance by subpoena. The results of an examination or investigation shall be provided to the carrier, third-party administrator, servicing agent, or other claims-handling entity in a written report setting forth the basis for any violations that are asserted. Such report is agency action for purposes of chapter 120, and the aggrieved party may request a proceeding under s. 120.57 with regard to the findings and conclusion of the report.

(4) If the department finds that violations of this chapter have occurred, the department may impose an administrative penalty upon the offending entity or entities. For each offending entity, such penalties shall not exceed \$2,500 for each pattern or practice constituting nonwillful violation and shall not exceed an aggregate amount of \$10,000 for all nonwillful violations arising out of the same action. If the department finds a pattern of practice that constitutes a willful violation, the department may impose an administrative penalty upon each offending entity not to exceed \$20,000 for each willful pattern or practice. Such fines shall not exceed \$100,000 for all willful violations arising out of the same action. No penalty assessed under this section may be recouped by any carrier in the rate base, the premium, or any rate filing. Any administrative penalty imposed under this section for a nonwillful violation shall not duplicate an administrative penalty imposed under another provision of this chapter or the Insurance Code. The department may adopt rules to implement this section. The department shall adopt penalty guidelines by rule to set penalties under this chapter.

Section 33. Subsection (2) of section 627.162, Florida Statutes, is amended to read:

627.162 Requirements for premium installments; delinquency, collection, and check return charges; attorney's fees.—

(2) Insurers providing workers' compensation coverage under chapter 440 may charge the insured a delinquency and collection fee on each installment in default for a period of not less than 5 days in an amount not to exceed ~~\$25~~ \$10 or 5 percent of the delinquent installment, whichever is greater. Only one such delinquency and collection fee may be collected on any such installment regardless of the period during which it remains in default.

Section 34. Section 627.285, Florida Statutes, is created to read:

627.285 Independent actuarial peer review of workers' compensation rating organization.—The Financial Services Commission shall at least once every other year contract for an independent actuarial peer review and analysis of the ratemaking processes of any licensed rating organization that makes rate filings for workers' compensation insurance and the rating organization shall fully cooperate in the peer review. The contract shall require submission of a final report to the commission, the President of the Senate, and the Speaker of the House of Representatives by February 1. The first report shall be submitted by February 1, 2004. The costs of the independent actuarial peer review shall be paid from the Workers' Compensation Administration Trust Fund.

Section 35. Effective July, 1, 2003, paragraphs (b), (c), and (d) of subsection (4) of section 627.311, Florida Statutes, are amended to read

627.311 Joint underwriters and joint reinsurers.—

(4)

(b) The operation of the plan is subject to the supervision of a ~~9-member~~ 13-member board of governors. The board of governors shall be comprised of:

1. Three members appointed by the Financial Services Commission. Each member appointed by the commission shall serve at the pleasure of the commission;

2.1. Two ~~Five~~ of the 20 domestic insurers, as defined in s. 624.06(1), having the largest voluntary direct premiums written in this state for workers' compensation and employer's liability insurance, which shall be elected by those 20 domestic insurers;

3.2. Two ~~Five~~ of the 20 foreign insurers as defined in s. 624.06(2) having the largest voluntary direct premiums written in this state for workers' compensation and employer's liability insurance, which shall be elected by those 20 foreign insurers;

- ~~3. One person, who shall serve as the chair, appointed by the Insurance Commissioner;~~
4. One person appointed by the largest property and casualty insurance agents' association in this state; and
5. The consumer advocate appointed under s. 627.0613 or the consumer advocate's designee.

Each board member shall serve a 4-year term and may serve consecutive terms. A vacancy on the board shall be filled in the same manner as the original appointment for the unexpired portion of the term. The Financial Services Commission shall designate a member of the board to serve as chair. No board member shall be an insurer which provides service to the plan or which has an affiliate which provides services to the plan or which is serviced by a service company or third-party administrator which provides services to the plan or which has an affiliate which provides services to the plan. The minutes, audits, and procedures of the board of governors are subject to chapter 119.

(c) The operation of the plan shall be governed by a plan of operation that is prepared at the direction of the board of governors. The plan of operation may be changed at any time by the board of governors or upon request of the department. The plan of operation and all changes thereto are subject to the approval of the department. The plan of operation shall:

1. Authorize the board to engage in the activities necessary to implement this subsection, including, but not limited to, borrowing money.
2. Develop criteria for eligibility for coverage by the plan, including, but not limited to, documented rejection by at least two insurers which reasonably assures that insureds covered under the plan are unable to acquire coverage in the voluntary market. Any insured may voluntarily elect to accept coverage from an insurer for a premium equal to or greater than the plan premium if the insurer writing the coverage adheres to the provisions of s. 627.171.
3. Require notice from the agent to the insured at the time of the application for coverage that the application is for coverage with the plan and that coverage may be available through an insurer, group self-insurers' fund, commercial self-insurance fund, or assessable mutual insurer through another agent at a lower cost.
4. Establish programs to encourage insurers to provide coverage to applicants of the plan in the voluntary market and to insureds of the plan, including, but not limited to:
 - a. Establishing procedures for an insurer to use in notifying the plan of the insurer's desire to provide coverage to applicants to the plan or existing insureds of the plan and in describing the types of risks in which the insurer is interested. The description of the desired risks must be on a form developed by the plan.

b. Developing forms and procedures that provide an insurer with the information necessary to determine whether the insurer wants to write particular applicants to the plan or insureds of the plan.

c. Developing procedures for notice to the plan and the applicant to the plan or insured of the plan that an insurer will insure the applicant or the insured of the plan, and notice of the cost of the coverage offered; and developing procedures for the selection of an insuring entity by the applicant or insured of the plan.

d. Provide for a market-assistance plan to assist in the placement of employers. All applications for coverage in the plan received 45 days before the effective date for coverage shall be processed through the market-assistance plan. A market-assistance plan specifically designed to serve the needs of small good policyholders as defined by the board must be finalized by January 1, 1994.

5. Provide for policy and claims services to the insureds of the plan of the nature and quality provided for insureds in the voluntary market.

6. Provide for the review of applications for coverage with the plan for reasonableness and accuracy, using any available historic information regarding the insured.

7. Provide for procedures for auditing insureds of the plan which are based on reasonable business judgment and are designed to maximize the likelihood that the plan will collect the appropriate premiums.

8. Authorize the plan to terminate the coverage of and refuse future coverage for any insured that submits a fraudulent application to the plan or provides fraudulent or grossly erroneous records to the plan or to any service provider of the plan in conjunction with the activities of the plan.

9. Establish service standards for agents who submit business to the plan.

10. Establish criteria and procedures to prohibit any agent who does not adhere to the established service standards from placing business with the plan or receiving, directly or indirectly, any commissions for business placed with the plan.

11. Provide for the establishment of reasonable safety programs for all insureds in the plan. All insureds of the plan must participate in the safety program.

12. Authorize the plan to terminate the coverage of and refuse future coverage to any insured who fails to pay premiums or surcharges when due; who, at the time of application, is delinquent in payments of workers' compensation or employer's liability insurance premiums or surcharges owed to an insurer, group self-insurers' fund, commercial self-insurance fund, or assessable mutual insurer licensed to write such coverage in this state; or who refuses to substantially comply with any safety programs recommended by the plan.

13. Authorize the board of governors to provide the services required by the plan through staff employed by the plan, through reasonably compensated service providers who contract with the plan to provide services as specified by the board of governors, or through a combination of employees and service providers.

14. Provide for service standards for service providers, methods of determining adherence to those service standards, incentives and disincentives for service, and procedures for terminating contracts for service providers that fail to adhere to service standards.

15. Provide procedures for selecting service providers and standards for qualification as a service provider that reasonably assure that any service provider selected will continue to operate as an ongoing concern and is capable of providing the specified services in the manner required.

16. Provide for reasonable accounting and data-reporting practices.

17. Provide for annual review of costs associated with the administration and servicing of the policies issued by the plan to determine alternatives by which costs can be reduced.

18. Authorize the acquisition of such excess insurance or reinsurance as is consistent with the purposes of the plan.

19. Provide for an annual report to the department on a date specified by the department and containing such information as the department reasonably requires.

20. Establish multiple rating plans for various classifications of risk which reflect risk of loss, hazard grade, actual losses, size of premium, and compliance with loss control. At least one of such plans must be a preferred-rating plan to accommodate small-premium policyholders with good experience as defined in sub-subparagraph 22.a.

21. Establish agent commission schedules.

22. Establish four ~~three~~ subplans as follows:

a. Subplan "A" must include those insureds whose annual premium does not exceed \$2,500 and who have neither incurred any lost-time claims nor incurred medical-only claims exceeding 50 percent of their premium for the immediate 2 years.

b. Subplan "B" must include insureds that are employers identified by the board of governors as high-risk employers due solely to the nature of the operations being performed by those insureds and for whom no market exists in the voluntary market, and whose experience modifications are less than 1.00.

c. Subplan "C" must include all ~~other~~ insureds within the plan that are not eligible for subplan "A," subplan "B," or subplan "D."

d. Subplan "D" must include any employer, regardless of the length of time for which it has conducted business operations, which has an experience modification factor of 1.10 or less and either employs 15 or fewer employees or is an organization that is exempt from federal income tax pursuant to s. 501(c)(3) of the Internal Revenue Code and receives more than 50 percent of its funding from gifts, grants, endowments, or federal or state contracts. The rate plan for subplan "D" shall be the same rate plan as the plan approved under ss. 627.091-627.151 and each participant in subplan "D" shall pay the premium determined under such rate plan, plus a surcharge determined by the board to be sufficient to ensure that the plan does not compete with the voluntary market rate for any participant, but not to exceed 25 percent. However, the surcharge shall not exceed 10 percent for an organization that is exempt from federal income tax pursuant to s. 501(c)(3) of the Internal Revenue Code.

23. Provide for a depopulation program to reduce the number of insureds in subplan "D." If an employer insured through subplan "D" is offered coverage from a voluntary market carrier:

- a. During the first 30 days of coverage under the subplan;
- b. Before a policy is issued under the subplan;
- c. By issuance of a policy upon expiration or cancellation of the policy under the subplan; or
- d. By assumption of the subplan's obligation with respect to an in-force policy,

that employer is no longer eligible for coverage through the plan. The premium for risks assumed by the voluntary market carrier must be the same premium plus, for the first 2 years, the surcharge as determined in sub-subparagraph 22.d. A premium under this subparagraph, including surcharge, is deemed approved and is not an excess premium for purposes of s. 627.171.

24. Require that policies issued under subplan "D" and applications for such policies must include a notice that the policy issued under subplan "D" could be replaced by a policy issued from a voluntary market carrier and that, if an offer of coverage is obtained from a voluntary market carrier, the policyholder is no longer eligible for coverage through subplan "D." The notice must also specify that acceptance of coverage under subplan "D" creates a conclusive presumption that the applicant or policyholder is aware of this potential.

(d)1. The plan must be funded through actuarially sound premiums charged to insureds of the plan.

2. The plan may issue assessable policies only to those insureds in subplan "C." and subplan "D." Subject to verification by the department, the board may levy assessments against insureds in subplan "C" or subplan "D," on a pro rata earned premium basis, to fund any deficits that exist in those subplans. Assessments levied against subplan "C" participants shall cover

only the deficits attributable to subplan "C," and assessments levied against subplan "D" participants shall cover only the deficits attributable to subplan "D." In no event may the plan levy assessments against any person or entity, except as authorized by this paragraph. Those assessable policies must be clearly identified as assessable by containing, in contrasting color and in not less than 10-point type, the following statements: "This is an assessable policy. If the plan is unable to pay its obligations, policyholders will be required to contribute on a pro rata earned premium basis the money necessary to meet any assessment levied."

3. The plan may issue assessable policies with differing terms and conditions to different groups within subplans "C" and "D" ~~the plan~~ when a reasonable basis exists for the differentiation.

4. The plan may offer rating, dividend plans, and other plans to encourage loss prevention programs.

Section 36. Paragraphs (c) and (e) of subsection (3) of section 921.0022, Florida Statutes, are amended to read:

921.0022 Criminal Punishment Code; offense severity ranking chart.—

(3) OFFENSE SEVERITY RANKING CHART

Florida Statute	Felony Degree	Description
		(c) LEVEL 3
316.193(2)(b)	3rd	Felony DUI, 3rd conviction.
316.1935(2)	3rd	Fleeing or attempting to elude law enforcement officer in marked patrol vehicle with siren and lights activated.
319.30(4)	3rd	Possession by junkyard of motor vehicle with identification number plate removed.
319.33(1)(a)	3rd	Alter or forge any certificate of title to a motor vehicle or mobile home.
319.33(1)(c)	3rd	Procure or pass title on stolen vehicle.
319.33(4)	3rd	With intent to defraud, possess, sell, etc., a blank, forged, or unlawfully obtained title or registration.
327.35(2)(b)	3rd	Felony BUI.
328.05(2)	3rd	Possess, sell, or counterfeit fictitious, stolen, or fraudulent titles or bills of sale of vessels.
328.07(4)	3rd	Manufacture, exchange, or possess vessel with counterfeit or wrong ID number.
376.302(5)	3rd	Fraud related to reimbursement for cleanup expenses under the Inland Protection Trust Fund.

Florida Statute	Felony Degree	Description
<u>440.105(3)(b)</u>	<u>3rd</u>	<u>Receipt of fee or consideration without approval by judge of compensation claims.</u>
<u>440.1051(3)</u>	<u>3rd</u>	<u>False report of workers' compensation fraud or retaliation for making such a report.</u>
501.001(2)(b)	2nd	Tampers with a consumer product or the container using materially false/misleading information.
697.08	3rd	Equity skimming.
790.15(3)	3rd	Person directs another to discharge firearm from a vehicle.
796.05(1)	3rd	Live on earnings of a prostitute.
806.10(1)	3rd	Maliciously injure, destroy, or interfere with vehicles or equipment used in fire-fighting.
806.10(2)	3rd	Interferes with or assaults firefighter in performance of duty.
810.09(2)(c)	3rd	Trespass on property other than structure or conveyance armed with firearm or dangerous weapon.
812.014(2)(c)2.	3rd	Grand theft; \$5,000 or more but less than \$10,000.
812.0145(2)(c)	3rd	Theft from person 65 years of age or older; \$300 or more but less than \$10,000.
815.04(4)(b)	2nd	Computer offense devised to defraud or obtain property.
817.034(4)(a)3.	3rd	Engages in scheme to defraud (Florida Communications Fraud Act), property valued at less than \$20,000.
817.233	3rd	Burning to defraud insurer.
817.234(8)&(9)	3rd	Unlawful solicitation of persons involved in motor vehicle accidents.
817.234(11)(a)	3rd	Insurance fraud; property value less than \$20,000.
817.505(4)	3rd	Patient brokering.
828.12(2)	3rd	Tortures any animal with intent to inflict intense pain, serious physical injury, or death.
831.28(2)(a)	3rd	Counterfeiting a payment instrument with intent to defraud or possessing a counterfeit payment instrument.

Florida Statute	Felony Degree	Description
831.29	2nd	Possession of instruments for counterfeiting drivers' licenses or identification cards.
838.021(3)(b)	3rd	Threatens unlawful harm to public servant.
843.19	3rd	Injure, disable, or kill police dog or horse.
870.01(2)	3rd	Riot; inciting or encouraging.
893.13(1)(a)2.	3rd	Sell, manufacture, or deliver cannabis (or other s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., (2)(c)5., (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (3), or (4) drugs).
893.13(1)(d)2.	2nd	Sell, manufacture, or deliver s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., (2)(c)5., (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (3), or (4) drugs within 200 feet of university or public park.
893.13(1)(f)2.	3rd	Sell, manufacture, or deliver s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., (2)(c)5., (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (3), or (4) drugs within 200 feet of public housing facility.
893.13(6)(a)	3rd	Possession of any controlled substance other than felony possession of cannabis.
893.13(7)(a)8.	3rd	Withhold information from practitioner regarding previous receipt of or prescription for a controlled substance.
893.13(7)(a)9.	3rd	Obtain or attempt to obtain controlled substance by fraud, forgery, misrepresentation, etc.
893.13(7)(a)10.	3rd	Affix false or forged label to package of controlled substance.
893.13(7)(a)11.	3rd	Furnish false or fraudulent material information on any document or record required by chapter 893.
893.13(8)(a)1.	3rd	Knowingly assist a patient, other person, or owner of an animal in obtaining a controlled substance through deceptive, untrue, or fraudulent representations in or related to the practitioner's practice.
893.13(8)(a)2.	3rd	Employ a trick or scheme in the practitioner's practice to assist a patient, other person, or owner of an animal in obtaining a controlled substance.
893.13(8)(a)3.	3rd	Knowingly write a prescription for a controlled substance for a fictitious person.

Florida Statute	Felony Degree	Description
893.13(8)(a)4.	3rd	Write a prescription for a controlled substance for a patient, other person, or an animal if the sole purpose of writing the prescription is a monetary benefit for the practitioner.
918.13(1)(a)	3rd	Alter, destroy, or conceal investigation evidence.
944.47(1)(a)1.-2.	3rd	Introduce contraband to correctional facility.
944.47(1)(c)	2nd	Possess contraband while upon the grounds of a correctional institution.
985.3141	3rd	Escapes from a juvenile facility (secure detention or residential commitment facility).
		(e) LEVEL 5
316.027(1)(a)	3rd	Accidents involving personal injuries, failure to stop; leaving scene.
316.1935(4)	2nd	Aggravated fleeing or eluding.
322.34(6)	3rd	Careless operation of motor vehicle with suspended license, resulting in death or serious bodily injury.
327.30(5)	3rd	Vessel accidents involving personal injury; leaving scene.
381.0041(11)(b)	3rd	Donate blood, plasma, or organs knowing HIV positive.
<u>440.10(1)(g)</u>	<u>2nd</u>	<u>Failure to obtain workers' compensation coverage.</u>
<u>440.105(5)</u>	<u>2nd</u>	<u>Unlawful solicitation for the purpose of making workers' compensation claims.</u>
<u>440.381(2)</u>	<u>2nd</u>	<u>Submission of false, misleading, or incomplete information with the purpose of avoiding or reducing workers' compensation premiums.</u>
790.01(2)	3rd	Carrying a concealed firearm.
790.162	2nd	Threat to throw or discharge destructive device.
790.163(1)	2nd	False report of deadly explosive or weapon of mass destruction.
790.221(1)	2nd	Possession of short-barreled shotgun or machine gun.
790.23	2nd	Felons in possession of firearms or electronic weapons or devices.

Florida Statute	Felony Degree	Description
800.04(6)(c)	3rd	Lewd or lascivious conduct; offender less than 18 years.
800.04(7)(c)	2nd	Lewd or lascivious exhibition; offender 18 years or older.
806.111(1)	3rd	Possess, manufacture, or dispense fire bomb with intent to damage any structure or property.
812.0145(2)(b)	2nd	Theft from person 65 years of age or older; \$10,000 or more but less than \$50,000.
812.015(8)	3rd	Retail theft; property stolen is valued at \$300 or more and one or more specified acts.
812.019(1)	2nd	Stolen property; dealing in or trafficking in.
812.131(2)(b)	3rd	Robbery by sudden snatching.
812.16(2)	3rd	Owning, operating, or conducting a chop shop.
817.034(4)(a)2.	2nd	Communications fraud, value \$20,000 to \$50,000.
817.234(11)(b)	2nd	Insurance fraud; property value \$20,000 or more but less than \$100,000.
817.568(2)(b)	2nd	Fraudulent use of personal identification information; value of benefit, services received, payment avoided, or amount of injury or fraud, \$75,000 or more.
817.625(2)(b)	2nd	Second or subsequent fraudulent use of scanning device or reencoder.
825.1025(4)	3rd	Lewd or lascivious exhibition in the presence of an elderly person or disabled adult.
827.071(4)	2nd	Possess with intent to promote any photographic material, motion picture, etc., which includes sexual conduct by a child.
839.13(2)(b)	2nd	Falsifying records of an individual in the care and custody of a state agency involving great bodily harm or death.
843.01	3rd	Resist officer with violence to person; resist arrest with violence.
874.05(2)	2nd	Encouraging or recruiting another to join a criminal street gang; second or subsequent offense.

Florida Statute	Felony Degree	Description
893.13(1)(a)1.	2nd	Sell, manufacture, or deliver cocaine (or other s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)4. drugs).
893.13(1)(c)2.	2nd	Sell, manufacture, or deliver cannabis (or other s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., (2)(c)5., (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (3), or (4) drugs) within 1,000 feet of a child care facility or school.
893.13(1)(d)1.	1st	Sell, manufacture, or deliver cocaine (or other s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)4. drugs) within 200 feet of university or public park.
893.13(1)(e)2.	2nd	Sell, manufacture, or deliver cannabis or other drug prohibited under s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., (2)(c)5., (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (3), or (4) within 1,000 feet of property used for religious services or a specified business site.
893.13(1)(f)1.	1st	Sell, manufacture, or deliver cocaine (or other s. 893.03(1)(a), (1)(b), (1)(d), or (2)(a), (2)(b), or (2)(c)4. drugs) within 200 feet of public housing facility.
893.13(4)(b)	2nd	Deliver to minor cannabis (or other s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., (2)(c)5., (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (3), or (4) drugs).

Section 37. Report to the Legislature regarding outstanding enforcement issues.—The Department of Financial Services shall, no later than January 1, 2004, provide a report to the President of the Senate, the Speaker of the House of Representatives, the minority leaders of the Senate and the House of Representatives, and the chairs of the standing committees of the Senate and the House of Representatives having jurisdiction over insurance issues, containing the following information:

(1) Any provision of chapter 440, Florida Statutes, relating to workers' compensation carrier compliance and enforcement, that the department finds it is unable to enforce.

(2) Any administrative rule relating to workers' compensation carrier compliance and enforcement that the department finds it is unable to enforce.

(3) Any other impediment to enforcement of chapter 440, Florida Statutes, resulting from the transfer of activities from the former Department of Labor and Employment Security to the department or the reorganization of the former Department of Insurance into the department.

Section 38. Subsection (2) of section 946.523, Florida Statutes, is amended to read:

946.523 Prison industry enhancement (PIE) programs.—

(2) Notwithstanding any other law to the contrary, including s. 440.15(8)(9), private sector employers shall provide workers' compensation coverage to inmates who participate in prison industry enhancement (PIE) programs under subsection (1). However, inmates are not entitled to unemployment compensation.

Section 39. Paragraph (c) of subsection (5) of section 985.315, Florida Statutes, is amended to read:

985.315 Educational/technical and vocational work-related programs.—

(5)

(c) Notwithstanding any other law to the contrary, including s. 440.15(8)(9), private sector employers shall provide juveniles participating in juvenile work programs under paragraph (b) with workers' compensation coverage, and juveniles shall be entitled to the benefits of such coverage. Nothing in this subsection shall be construed to allow juveniles to participate in unemployment compensation benefits.

Section 40. (1) There is established a Joint Select Committee on Workers' Compensation Rating Reform. The committee shall study the merits of requiring each workers' compensation insurer to individually file its expense and profit portion of a rate filing, while permitting each insurer to use a lost cost filing made by a licensed rating organization. The committee shall also study options for the current prior approval system for workers compensation rate filings, including, but not limited to, rate filing procedures that would promote greater competition and would encourage insurers to write workers' compensation coverage in the state while protecting employers from rates that are excessive, inadequate, or unfairly discriminatory.

(2) The committee shall be composed of three Senators appointed by the President of the Senate and three Representatives appointed by the Speaker of the House of Representatives. The appointed members of the committee shall elect a chair and vice chair. The Department of Financial Services shall provide information and assistance as requested by the committee.

(3) The committee shall issue its final report and recommendations to the President of the Senate and the Speaker of the House of Representatives by December 1, 2003. The committee shall terminate on December 1, 2003.

Section 41. The board of governors of the joint underwriting plan for workers' compensation insurance created by section 627.311(4), Florida Statutes, shall, by January 1, 2005, submit a report to the President of the Senate, the Speaker of the House of Representatives, the minority party leaders of the Senate and the House of Representatives, and the chairs of the standing committees of the Senate and the House of Representatives having jurisdiction over matters relating to workers' compensation. The

report shall include the board's findings and recommendations on the following issues:

(1) The number of policies and the aggregate premium of the workers' compensation joint underwriting plan, before and after enactment of this act, and projections for future policy and premium growth.

(2) Increases or decreases in availability of workers' compensation coverage in the voluntary market and the effectiveness of this act in improving the availability of workers' compensation coverage in the state.

(3) The board's efforts to depopulate the plan and the willingness of insurers in the voluntary market to avail themselves of depopulation incentives.

(4) Further actions that could be taken by the Legislature to improve availability of workers' compensation coverage in the voluntary and residual markets.

(5) Actions that the board has taken to restructure the joint underwriting plan and recommendations for legislative action to restructure the plan.

(6) Projected surpluses or deficits and possible means of providing funding to ensure the continued solvency of the plan.

(7) An independent actuarial review of all rates under the plan. The costs of the independent actuarial review shall be paid from the Workers' Compensation Administration Trust Fund, pursuant to a budget amendment approved by the Legislative Budget Commission. The board shall submit a plan for such review to the Legislative Budget Commission by October 1, 2003.

(8) Such other issues as the board determines are worthy of the Legislature's consideration.

Section 42. Subsections (1) and (2) of section 443.1715, Florida Statutes, are amended to read:

443.1715 Disclosure of information; confidentiality.—

(1) RECORDS AND REPORTS.—Information revealing the employing unit's or individual's identity obtained from the employing unit or from any individual pursuant to the administration of this chapter, and any determination revealing such information, except to the extent necessary for the proper presentation of a claim or upon written authorization of the claimant who has a workers' compensation claim pending or is receiving compensation benefits, must be held confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution. Such information may be made available only to public employees in the performance of their public duties, including employees of the Department of Education in obtaining information for the Florida Education and Training Placement Information Program and the Office of Tourism, Trade, and Economic Development in its administration of the qualified defense contractor tax refund

program authorized by s. 288.1045 and the qualified target industry tax refund program authorized by s. 288.106. Except as otherwise provided by law, public employees receiving such information must retain the confidentiality of such information. Any claimant, or the claimant's legal representative, at a hearing before an appeals referee or the commission shall be supplied with information from such records to the extent necessary for the proper presentation of her or his claim. Any employee or member of the commission or any employee of the division, or any other person receiving confidential information, who violates any provision of this subsection commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083. However, the division may furnish to any employer copies of any report previously submitted by such employer, upon the request of such employer, and may furnish to any claimant copies of any report previously submitted by such claimant, upon the request of such claimant, and the division is authorized to charge therefor such reasonable fee as the division may by rule prescribe not to exceed the actual reasonable cost of the preparation of such copies. Fees received by the division for copies as provided in this subsection must be deposited to the credit of the Employment Security Administration Trust Fund.

(2) DISCLOSURE OF INFORMATION.—

(a) Subject to such restrictions as the division prescribes by rule, information declared confidential under this section may be made available to any agency of this or any other state, or any federal agency, charged with the administration of any unemployment compensation law or the maintenance of a system of public employment offices, or the Bureau of Internal Revenue of the United States Department of the Treasury, or the Florida Department of Revenue and information obtained in connection with the administration of the employment service may be made available to persons or agencies for purposes appropriate to the operation of a public employment service or a job-preparatory or career education or training program. The division shall on a quarterly basis, furnish the National Directory of New Hires with information concerning the wages and unemployment compensation paid to individuals, by such dates, in such format and containing such information as the Secretary of Health and Human Services shall specify in regulations. Upon request therefor, the division shall furnish any agency of the United States charged with the administration of public works or assistance through public employment, and may furnish to any state agency similarly charged, the name, address, ordinary occupation, and employment status of each recipient of benefits and such recipient's rights to further benefits under this chapter. Except as otherwise provided by law, the receiving agency must retain the confidentiality of such information as provided in this section. The division may request the Comptroller of the Currency of the United States to cause an examination of the correctness of any return or report of any national banking association rendered pursuant to the provisions of this chapter and may in connection with such request transmit any such report or return to the Comptroller of the Currency of the United States as provided in s. 3305(c) of the federal Internal Revenue Code.

(b)1. The employer or the employer's workers' compensation carrier against whom a claim for benefits under chapter 440 has been made, or a

representative of either, may request from the division records of wages of the employee reported to the division by any employer for the quarter that includes the date of the accident that is the subject of such claim and for subsequent quarters. The request must be made with the authorization or consent of the employee or any employer who paid wages to the employee subsequent to the date of the accident.

2. The employer or carrier shall make the request on a form prescribed by rule for such purpose by the division. Such form shall contain a certification by the requesting party that it is a party entitled to the information requested as authorized by this paragraph.

3. The division shall provide the most current information readily available within 15 days after receiving the request.

Section 43. Subsection (9) of section 626.989, Florida Statutes, is amended to read:

626.989 Investigation by department or Division of Insurance Fraud; compliance; immunity; confidential information; reports to division; division investigator's power of arrest.—

(9) In recognition of the complementary roles of investigating instances of workers' compensation fraud and enforcing compliance with the workers' compensation coverage requirements under chapter 440, the Department of ~~Financial Services shall Insurance is directed to~~ prepare and submit a joint performance report to the President of the Senate and the Speaker of the House of Representatives by November 1, 2003, and then by January 1 of each year November 1 every 3 years thereafter, describing the results obtained in achieving compliance with the workers' compensation coverage requirements and reducing the incidence of workers' compensation fraud. The annual report must include, but need not be limited to:

(a) The total number of initial referrals received, cases opened, cases presented for prosecution, cases closed, and convictions resulting from cases presented for prosecution by the Bureau of Workers' Compensation Insurance Fraud by type of workers' compensation fraud and circuit.

(b) The number of referrals received from insurers and the Division of Workers' Compensation and the outcome of those referrals.

(c) The number of investigations undertaken by the office which were not the result of a referral from an insurer or the Division of Workers' Compensation.

(d) The number of investigations that resulted in a referral to a regulatory agency and the disposition of those referrals.

(e) The number and reasons provided by local prosecutors or the state-wide prosecutor for declining prosecution of a case presented by the office by circuit.

(f) The total number of employees assigned to the office and the Division of Workers' Compliance unit delineated by location of staff assigned and the

number and location of employees assigned to the office who were assigned to work other types of fraud cases.

(g) The average caseload and turnaround time by type of case for each investigator and division compliance employee.

(h) The training provided during the year to workers' compensation fraud investigators and the division's compliance employees.

Section 44. Section 626.9891, Florida Statutes, is amended to read:

626.9891 Insurer anti-fraud investigative units; reporting requirements; penalties for noncompliance.—

(1) Every insurer admitted to do business in this state who in the previous calendar year, at any time during that year, had \$10 million or more in direct premiums written shall:

(a) Establish and maintain a unit or division within the company to investigate possible fraudulent claims by insureds or by persons making claims for services or repairs against policies held by insureds; or

(b) Contract with others to investigate possible fraudulent claims for services or repairs against policies held by insureds.

An insurer subject to this subsection shall file with the Division of Insurance Fraud of the department on or before July 1, 1996, a detailed description of the unit or division established pursuant to paragraph (a) or a copy of the contract and related documents required by paragraph (b).

(2) Every insurer admitted to do business in this state, which in the previous calendar year had less than \$10 million in direct premiums written, must adopt an anti-fraud plan and file it with the Division of Insurance Fraud of the department on or before July 1, 1996. An insurer may, in lieu of adopting and filing an anti-fraud plan, comply with the provisions of subsection (1).

(3) Each insurers anti-fraud plans shall include:

(a) A description of the insurer's procedures for detecting and investigating possible fraudulent insurance acts;

(b) A description of the insurer's procedures for the mandatory reporting of possible fraudulent insurance acts to the Division of Insurance Fraud of the department;

(c) A description of the insurer's plan for anti-fraud education and training of its claims adjusters or other personnel; and

(d) A written description or chart outlining the organizational arrangement of the insurer's anti-fraud personnel who are responsible for the investigation and reporting of possible fraudulent insurance acts.

(4) Any insurer who obtains a certificate of authority after July 1, 1995, shall have 18 months in which to comply with the requirements of this section.

(5) For purposes of this section, the term “unit or division” includes the assignment of fraud investigation to employees whose principal responsibilities are the investigation and disposition of claims. If an insurer creates a distinct unit or division, hires additional employees, or contracts with another entity to fulfill the requirements of this section, the additional cost incurred must be included as an administrative expense for ratemaking purposes.

(6) Each insurer writing workers’ compensation insurance shall report to the department, on or before August 1 of each year, on its experience in implementing and maintaining an anti-fraud investigative unit or an anti-fraud plan. The report must include, at a minimum:

(a) The dollar amount of recoveries and losses attributable to workers’ compensation fraud delineated by the type of fraud: claimant, employer, provider, agent, or other.

(b) The number of referrals to the Bureau of Workers’ Compensation Fraud for the prior year.

(c) A description of the organization of the anti-fraud investigative unit, if applicable, including the position titles and descriptions of staffing.

(d) The rationale for the level of staffing and resources being provided for the anti-fraud investigative unit, which may include objective criteria such as number of policies written, number of claims received on an annual basis, volume of suspected fraudulent claims currently being detected, other factors, and an assessment of optimal caseload that can be handled by an investigator on an annual basis.

(e) The in-service education and training provided to underwriting and claims personnel to assist in identifying and evaluating instances of suspected fraudulent activity in underwriting or claims activities.

(f) A description of a public awareness program focused on the costs and frequency of insurance fraud and methods by which the public can prevent it.

(7) If an insurer fails to submit a final anti-fraud plan or otherwise fails to submit a plan, fails to implement the provisions of a plan or an anti-fraud investigative unit, or otherwise refuses to comply with the provisions of this section, the department may:

(a) Impose an administrative fine of not more than \$2,000 per day for such failure by an insurer, until the department deems the insurer to be in compliance;

(b) Impose upon the insurer a fraud detection and prevention plan that is deemed to be appropriate by the department and that must be implemented by the insurer; or

- (c) Impose the provisions of both paragraphs (a) and (b).
- (8) The department may adopt rules to administer this section.

Section 45. Section 440.1925, Florida Statutes, is repealed.

Section 46. Paragraph (h) of subsection (2) of section 112.19, Florida Statutes, is amended to read:

112.19 Law enforcement, correctional, and correctional probation officers; death benefits.—

(2)

(h)1. Any employer who employs a full-time law enforcement, correctional, or correctional probation officer who, on or after January 1, 1995, suffers a catastrophic injury, as defined in s. 440.02, Florida Statutes 2002, in the line of duty shall pay the entire premium of the employer's health insurance plan for the injured employee, the injured employee's spouse, and for each dependent child of the injured employee until the child reaches the age of majority or until the end of the calendar year in which the child reaches the age of 25 if the child continues to be dependent for support, or the child is a full-time or part-time student and is dependent for support. The term "health insurance plan" does not include supplemental benefits that are not part of the basic group health insurance plan. If the injured employee subsequently dies, the employer shall continue to pay the entire health insurance premium for the surviving spouse until remarried, and for the dependent children, under the conditions outlined in this paragraph. However:

a. Health insurance benefits payable from any other source shall reduce benefits payable under this section.

b. It is unlawful for a person to willfully and knowingly make, or cause to be made, or to assist, conspire with, or urge another to make, or cause to be made, any false, fraudulent, or misleading oral or written statement to obtain health insurance coverage as provided under this paragraph. A person who violates this sub-subparagraph commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

c. In addition to any applicable criminal penalty, upon conviction for a violation as described in sub-subparagraph b., a law enforcement, correctional, or correctional probation officer or other beneficiary who receives or seeks to receive health insurance benefits under this paragraph shall forfeit the right to receive such health insurance benefits, and shall reimburse the employer for all benefits paid due to the fraud or other prohibited activity. For purposes of this sub-subparagraph, "conviction" means a determination of guilt that is the result of a plea or trial, regardless of whether adjudication is withheld.

2. In order for the officer, spouse, and dependent children to be eligible for such insurance coverage, the injury must have occurred as the result of the officer's response to fresh pursuit, the officer's response to what is reasonably believed to be an emergency, or an unlawful act perpetrated by

another. Except as otherwise provided herein, nothing in this paragraph shall be construed to limit health insurance coverage for which the officer, spouse, or dependent children may otherwise be eligible, except that a person who qualifies under this section shall not be eligible for the health insurance subsidy provided under chapter 121, chapter 175, or chapter 185.

Section 47. Paragraph (g) of subsection (2) of section 112.191, Florida Statutes, is amended to read:

112.191 Firefighters; death benefits.—

(2)

(g)1. Any employer who employs a full-time firefighter who, on or after January 1, 1995, suffers a catastrophic injury, as defined in s. 440.02, Florida Statutes 2002, in the line of duty shall pay the entire premium of the employer's health insurance plan for the injured employee, the injured employee's spouse, and for each dependent child of the injured employee until the child reaches the age of majority or until the end of the calendar year in which the child reaches the age of 25 if the child continues to be dependent for support, or the child is a full-time or part-time student and is dependent for support. The term "health insurance plan" does not include supplemental benefits that are not part of the basic group health insurance plan. If the injured employee subsequently dies, the employer shall continue to pay the entire health insurance premium for the surviving spouse until remarried, and for the dependent children, under the conditions outlined in this paragraph. However:

a. Health insurance benefits payable from any other source shall reduce benefits payable under this section.

b. It is unlawful for a person to willfully and knowingly make, or cause to be made, or to assist, conspire with, or urge another to make, or cause to be made, any false, fraudulent, or misleading oral or written statement to obtain health insurance coverage as provided under this paragraph. A person who violates this sub-subparagraph commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

c. In addition to any applicable criminal penalty, upon conviction for a violation as described in sub-subparagraph b., a firefighter or other beneficiary who receives or seeks to receive health insurance benefits under this paragraph shall forfeit the right to receive such health insurance benefits, and shall reimburse the employer for all benefits paid due to the fraud or other prohibited activity. For purposes of this sub-subparagraph, "conviction" means a determination of guilt that is the result of a plea or trial, regardless of whether adjudication is withheld.

2. In order for the firefighter, spouse, and dependent children to be eligible for such insurance coverage, the injury must have occurred as the result of the firefighter's response to what is reasonably believed to be an emergency involving the protection of life or property, or an unlawful act perpetrated by another. Except as otherwise provided herein, nothing in this paragraph shall be construed to limit health insurance coverage for which

the firefighter, spouse, or dependent children may otherwise be eligible, except that a person who qualifies for benefits under this section shall not be eligible for the health insurance subsidy provided under chapter 121, chapter 175, or chapter 185.

Section 48. The amendments to sections 440.02 and 440.15, Florida Statutes, which are made by this act shall not be construed to affect any determination of disability under section 112.18, section 112.181, or section 112.19, Florida Statutes.

Section 49. If any law amended by this act was also amended by a law enacted at the 2003 Regular Session of the Legislature, such laws shall be construed as if they had been enacted at the same session of the Legislature, and full effect shall be given to each if possible.

Section 50. Except as otherwise provided herein, this act shall take effect October 1, 2003.

Approved by the Governor July 15, 2003.

Filed in Office Secretary of State July 15, 2003.